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Illinois Medical Journal
OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY
Vol. 137, No. 1
January, 1970
Table of Contents page 5

MALPRACTICE / PEER REVIEW

CONFIDENTIAL

See page 44...



One hundred per cent of all travelers who have traveled 200,000 miles or more away from home have relied on Lomotil to control diarrhea.

When your patients need a reliable antidiarrheal — at
home or away from home — rely on Lomotil.

In diarrheas associated with:

- gastroenteritis
- acute infections
- functional hypermotility
- irritable bowel
- ileostomy
- drug-induced diarrhea

Warnings: Lomotil should be used with caution in patients taking barbiturates and, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Signs of accidental overdosage may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachy-

cardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

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TABLETS/LIQUID

Each Lomotil tablet and each 5 cc. of Lomoliquid contain:

diphenoxylate hydrochloride 2.5
(Warning: May be habit forming)
atropine sulfate 0.025

Children:

3-6 mo. 1/2 tsp. t.i.d. (3)
6-12 mo. 1/2 tsp. q.i.d. (4)
1-2 yr. 1/2 tsp. 5 times daily (5)
2-5 yr. 1 tsp. t.i.d. (6)
5-8 yr. 1 tsp. q.i.d. (8)
8-12 yr. 1 tsp. 5 times daily (10)
Adults: 2 tsp. 5 times daily (20)
or 2 tablets

*Based on 4 cc. per teaspoonful
Maintenance dosage may be as low as one-fifth the initial daily dosage.

G. D. SEARLE & CO. Research in the Service of Medicine

P. O. Box 5110, Chicago, Illinois 60680

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Illinois Medical Journal

volume 137, number 1

january, 1970



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CLINICAL ARTICLES

A New Insight for the Gastrointestinal Surgeon Jack H. Sanders, M.D.	33
Management of Severe Status Asthmaticus Anthony D. Ivankovic, M.D., and Christen C. Rattenborg, M.D.	35
Confrontation Technique Applied to Delirium and Confusional States H. H. Garner, M.D.	71
Successful Pregnancy in a Woman with Severe Uremia Maria H. Balkoura, M.D., Maruti S. Bhorade, M.D., Sheldon M. Kahn, M.D., and George Dunca, M.B.	80

SURGICAL GRAND ROUNDS

Adrenal Neoplasm	47
------------------------	----

MEDICAL PROGRESS

Oral Treatment of Iron Deficiency Anemia Oliver W. Crawford, M.D.	60
---	----

SPECIAL ARTICLES

Raising Brighter Children Arthur L. Ennis, M.D.	38
History of Urology in Illinois Joseph H. Kiefer, M.D.	54
The Medical Aspects of Professional Baseball Joseph R. Suker, M.D.	89
IMJ 1969 Membership Survey Analysis—III	65

1970 LEADERSHIP CONFERENCE

FEATURES

The President's Page	10
New Pharmaceutical Specialties	20
Editorials	40
Clinics for Crippled Children	41
The Doctor's Library	42
The View Box	52
Membership Forum	53
Physicians Placement Service	64
Public Affairs Library	75
Meeting Memos	78
Socio-Economic News	83
Illinois Medical Assistants Association	88
Obituaries	93

(Cover story on page 20)

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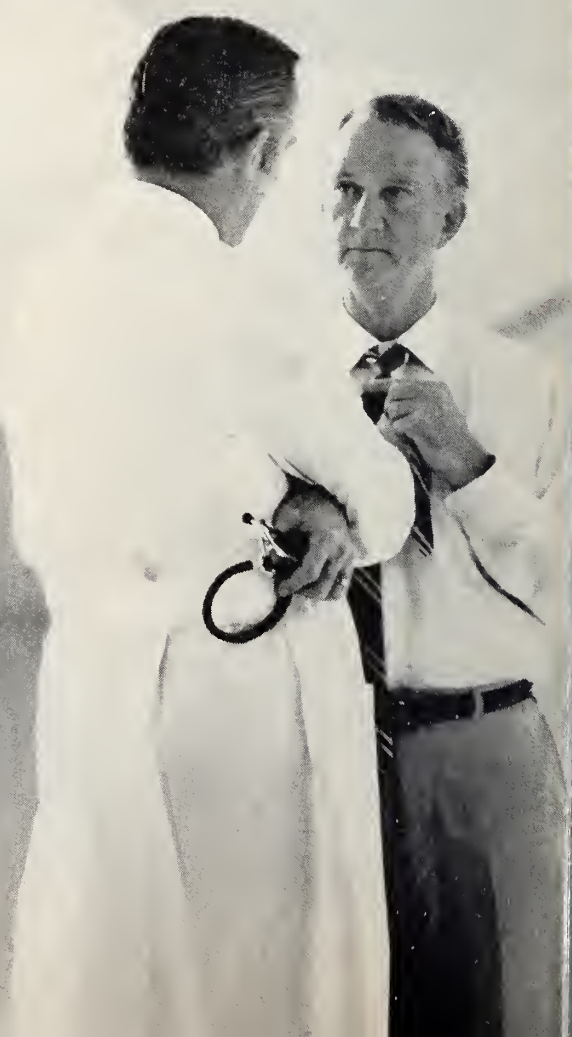
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BLUE SHIELD REPORT



FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 222 NORTH DEARBORN ST. • CHICAGO, ILLINOIS 60601

Vol. 4, No. 1

January, 1970

New Blue Shield Benefits Broaden Basic Coverage

Effective February 1, 1970, three new benefits will be added to Illinois Blue Shield group certificates, with *no increase in Blue Shield rates*.

The benefits added are:

1. Coordinated Home Care Service
2. Extended Care Facility Service
3. Emergency Medical Service

These new benefits will add important protection for Blue Shield members requiring medical care outside the hospital, and for those already confined to the hospital who do not require continuous in-patient care for effective treatment.

Coordinated Home Care Service

Blue Shield will extend the present in-hospital medical benefit payments to a physician for medical care visits to a patient at home who is receiving approved Blue Cross coordinated home care service. The number of visits and dollar amounts payable for in-hospital medical care within each particular Blue Shield certificate will also apply to coordinated home care service. To be eligible for benefits, the member must be transferred directly from the hospital into the home care program by the attending physician with no break in his confinement. The patient must also require care which is directly related to the condition for which he was hospitalized and which can be provided at home under the direction of his own physician.

Extended Care Facility Service

Blue Shield will extend the present in-hospital medical benefit to provide payment to a physician for medical care visits to a patient transferred into an approved extended care facility. To be eligible for benefits, the member must be discharged from the hospital and transferred directly into the extended care facility. A member may also transfer directly from a coordinated home care program to an extended care facility, with no break in treatment.

The number of visits and dollar amounts payable for in-hospital medical care in a particular Blue Shield certificate will also apply to extended care facility service. In determining the total medical benefits, visits will be counted from the beginning of the hospital confinement.

Emergency Medical Service

Blue Shield will make payment to a physician for services required by a member as a result of a medical emergency regardless of whether the care is given in the out-patient department of a hospital, a clinic, the doctor's office or elsewhere. The payment to the physician shall be that amount payable under the same Blue Shield certificate for emergency accident care. The benefit payment is made by Blue Shield when service is received within 72 hours of the onset of the medical emergency.

A medical emergency involves a sudden and serious illness which requires urgent and immediate medical attention. Determination of a sudden and serious illness in individual cases will be based on the diagnosis and opinion of the attending physician.

The following diagnoses are some examples of conditions normally considered sudden and serious:

Acute coronary; Acute hemorrhage
Asthmatic attack; Severe Epistaxis
Food poisoning;
Convulsions; Hysterical reactions
Coma; Shock; Stroke
Acute abdominal pain or appendicitis
Foreign body in Eye, Ear, Nose or Throat
Acute psychotic episodes

The above is not a definitive list. The intent of the contract is to provide for "emergency" type of treatment but not for routine home and office care.

These added benefits will not automatically be incorporated into programs or certificates designed for national groups such as Steel, Motors, Federal Employees, etc. Also the new benefits will not be incorporated with the special Blue Shield over-65 coverages supplementing Medicare; namely, the Series 65 Major Medical and Blue Shield 65.

Benefit riders will be written for these three benefit additions and issued to present subscribers. Blue Shield certificates will be changed to include this broader coverage, and will be issued to new subscribers.

Broadening the scope of the basic coverage to include these important out-of-hospital services is another step by Blue Shield to extend more comprehensive health care benefits to all its members.

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Information Needed to Pay Medicare Claim

Before a Medicare claim can be processed, the 1490, "Request for Payment" form or the attached bills must be fully itemized.

Listed below is the information which is needed but often omitted:

Part I of the 1490

- 1) patient's name
- 2) health insurance claim number
- 3) address
- 4) sex
- 5) diagnosis or description of illness or injury
- 6) signature of the patient

Part II of the 1490 or attached bills

- 1) date of each service
- 2) description of each service rendered
- 3) charge for each service
- 4) name and address of physician who rendered the service
- 5) whether or not the claim is assigned
- 6) signature of the physician when assignment is accepted.

Please review all claims for completeness before submitting them to the Part B Medicare carrier (Blue Shield for the counties of Cook, DuPage, Kane, Lake and Will). By including all necessary information on the 1490 or an itemized statement, you will help us prevent delays in making payments to you or to your patient.

Part A and Part B Increases Announced

Effective July 1, 1970, the Part B premiums will be raised from \$4.00 to \$5.30 per month. This increase will help cover the benefit payments which have risen to \$1.6 billion during the last fiscal year from \$664 million during the 1967 fiscal year.

The Social Security Administration has also found it necessary to increase the deductible and co-insurance portion of Medicare for which the beneficiary is responsible. Beginning January 1, 1970, the Part A deductible will be raised from \$44.00 to \$52.00.

The co-insurance—that portion the beneficiary pays—from the sixty-first to the ninetieth day of hospitalization will be raised from \$11.00 to \$13.00 a day and from \$22.00 a day to \$26.00 for each day used of the lifetime reserve. A beneficiary in an extended care facility beginning January 1, will be responsible to pay \$6.50 a day from the twenty-first to the one-hundredth day of care.

Part B Coverage of Medical and Surgical Services

Part B of Medicare will allow payments for covered medical and surgical services and consultations, office, home and hospital visits when medically necessary and when rendered by doctors of medicine or osteopathy. Certain services provided by doctors of dental medicine or doctors of dental surgery and certain services rendered by podiatrists are also covered.

Payment will be made at the rate of 80% of usual or customary charges. Routine examinations are not a benefit. The Social Security Administration defines an examination as routine when "performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint or injury."

Supplies such as gauze, ointments, bandages and drugs or biologicals are covered as these supplies are commonly furnished by the physician while performing his services.

Drugs and biologicals are covered only if:

- 1) they cannot be self-administered;
- 2) they are administered by the physician or rendered under the physician's personal supervision;
- 3) they are "reasonable and necessary" for the treatment of the illness or injury.

Inoculations, vaccinations, prescription drugs, drugs or biologicals which can be self-administered are excluded from the scope of Medicare benefits.

Portable X-Rays

Effective January 1, 1968, diagnostic portable X-Ray service is covered by the Medicare program when the service is provided at the patient's residence or at a non-participating institution.

Reimbursement can be made for X-Rays when they are ordered by the physician and performed by portable X-Ray suppliers who meet State health and safety standards.

The Medicare scope of benefits for portable X-Ray includes skeletal films involving arms, legs, pelvis, skull and vertebral column; chest films which do not involve the use of contrast media; abdominal films which do not involve the use of contrast media.

Routine screening procedures and tests in connection with routine physical examinations are excluded from Medicare coverage. The claim for portable X-Ray services involving the chest should include the reason why the X-Ray was taken.

It is also necessary to have the name of the physician ordering the X-Ray, the type of X-Ray taken, the date of the service and the charge for each service on the statement of "Request for Payment" form before the claim can be processed.

in responsive
arteriosclerosis obliterans

VASODILAN[®]

(ISOXSUPRINE HCl)

- acts directly to relax arterial musculature
- measurably increases blood flow to deep muscle arteries¹⁻³
- improves walking ability, relieves rest pain³⁻⁵
- is not contraindicated in coronary disease, diabetes, or peptic ulcer^{3,6,7}

to guide you in prescribing Vasodilan

Although not all clinicians agree on the value of peripheral vasodilators,⁸⁻¹⁰ several investigators^{3,6} have reported favorably on the effects of isoxsuprine on peripheral blood flow in skeletal muscle vessels. Effects have been demonstrated both by objective measurement^{1,6,11} and observation of clinical improvement.^{3-5,12}

Indications: Arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebotic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **Composition:** VASODILAN tablets, isoxsuprine hydrochloride 10 mg. **Dosage:** Oral—10 to 20 mg. (1 or 2 tablets) t.i.d. or q.i.d. **Contraindications and Cautions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10 mg. or more may cause brief hypotension and tachy-

cardia, single intramuscular doses exceeding this amount are not recommended. Complete details available in product brochure from Mead Johnson Laboratories.

References: (1) Stein, I. D.: *Angiology* 15:1 (April) 1964. (2) New Drugs—Evaluated by the A.M.A. Council on Drugs, Chicago, American Medical Association, 1967, pp. 295-297. (3) Kaindl, F.; Pärtan, J., and Polsterer, P.: *Wien. klin. Wchnschr.* 68:186-191 (March 16) 1956. (4) Friehe, C., and Olivier, L.: *Lyon Med.* 91:891-896 (May 24) 1959. (5) Weghaupt, Von K.: *Wien. klin. Wchnschr.* 69:31-32 (Jan. 11) 1957. (6) Kaindl, F.; Samuels, S. S.; Selman, D., and Shaftel, H.: *Angiology* 10:185-192 (Aug.) 1959. (7) Samuels, S. S., and Shaftel, H. E.: *J. Indiana M. A.* 54:1021-1023 (July) 1961. (8) Myers, K. A.: *Modern Treatment* 4:370-383 (March) 1967. (9) Gillespie, J. A.: *Angiology* 17:280-288 (May) 1966. (10) Smit, Arne, F., et al.: *Nordisk Medicin* 20:1260, 1959. (11) Samuels, S. S., and Shaftel, H. E.: *JAMA* 171:142-145 (Sept. 12) 1959. (12) Clarkson, I. S., and LePere, D. M.: *Angiology* 11:190-192 (June) 1960. © 1969 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 63569

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microphoto of small artery occlusions in toe amputated because of severe arteriosclerosis obliterans. Cast was made by injecting acrylic plastic into vessels. The occluded vessels measure about 30 to 50 microns in diameter. Used with permission. Courtesy of Margaret C. Conrad, Ph.D., Department of Physiology, Bowman Gray School of Medicine, Wake Forest College, Winston-Salem, N. C.



Edward W. Cannady, M.D.

The President's Page

At the onset of my term as president, I invited the officers of ISMS to share the President's Page with me as a means of expression. This month President-elect J. Ernest Breed through this medium indicates his feelings regarding patient responsibilities. In future issues other officers may also furnish material for your consideration.

E. W. Cannady, M.D.

Patient Responsibility

The most fundamental requirement for the delivery of adequate medical care is complete cooperation between two people, the doctor and his patient. Other factors may greatly influence the quality of care, but the basic responsibility rests between the physician who provides services and the patient who must be willing to accept them.

Some elements of the press have strongly criticized the medical profession when segments of the population have not received sufficient care. The doctor is blamed for the lack of adequate facilities in the ghetto and in rural areas, for the high infant mortality among the poor, and most other deficiencies in the health field. He is even blamed for the rapidly increasing cost of hospitalization and drugs.

To deliver adequate medical care to all people is difficult and increasingly more complicated. The medical societies, medical schools, and nearly all doctors are working to solve the many problems involved. The federal, state and local governments together with many lay organizations and private citizens are assisting in many ways. Most efforts are expended in attempting to provide care and few in encouraging the patient to receive it. While most patients are eager to cooperate there are some who refuse through ignorance, prejudice or some other reason.

Fear

Fear often makes the patient delay seeking aid. Fear that a suspicion of serious

disease may be confirmed causes some patients with cancer to present themselves only when pain or hemorrhage forces them to seek assistance. Fear of being hurt by needle insertions or other procedures keeps some from consulting a physician even when they know something is wrong. Fear of pain makes others neglect their teeth until they are destroyed by decay or infection.

Lack of Confidence

Lack of confidence in the medical profession is often instilled by an antagonistic press or by federal agency insinuations that some physicians are dishonest. These derogatory statements undoubtedly cause some patients to delay seeking medical aid. Lack of confidence may be due to the influence of a disgruntled friend who has had an unfortunate experience with a physician or from publicity given malpractice suits. Faith in his doctor is a necessity for all patients. Those who lack confidence may delay consulting a doctor, may question the diagnosis and may refuse the prescribed treatments.

Poor Advice From Others

Bad advice from relatives or friends frequently diverts the patient from seeking aid. It is with his close associates that he first discusses his symptoms. Since everyone has a pet cure and enjoys giving advice, valuable time may be wasted. Quacks or partially trained persons may offer erroneous advice.
(Continued on page 94)

significant clinical advantages of Librium (chlordiazepoxide HCl) confirmed in a wide range of conditions with an anxiety component



Today, Librium (chlordiazepoxide HCl) is well known as a dependable calming agent when anxiety is a significant component of the clinical profile. Although clinical performance cannot be extrapolated from experimental procedures and results, animal studies on Librium indicating a selective action on the limbic system may help explain the characteristic "Librium effect" in therapy, *i.e.*, a calming influence without undue loss of mental acuity when the drug is given in proper maintenance dosage. Should the patient require extended anti-anxiety therapy, Librium is particularly suitable because its benefits are usually maintained without need for increased dosage.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but

are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

For relief of anxiety

Librium®
(chlordiazepoxide HCl)

5-mg, 10-mg, 25-mg capsules

when tablets are preferred—

Libritabs®
(chlordiazepoxide)

5-mg, 10-mg, 25-mg tablets



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NEW

PHARMACEUTICAL SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

The following new drugs have been marketed:

NEW SINGLE CHEMICALS

CYTOSTAR Cancer Chemotherapy R

Manufacturer: Upjohn

Nonproprietary Name: Cytarabine HCl (USAN)

Indications: Induction of remission in acute granulocytic leukemia of adults and other acute leukemias of adults and children.

Contraindications: Pre-existing drug-induced bone marrow suppression.

Dosage: Rapid injection—Continuous Treatment 2 mg./kg./day to 4 mg./kg./day after 10 days.

Infusion—Continuous Treatment

0.5 to 1.0 mg./kg./day to 2.0 mg./kg./day after 10 days.

Continuous supervision of patient needed.

Supplied: Freeze-dried prep. in multidose vials—100 and 500 mg.

SINEQUAN Psychotherapeutic Agent R

Manufacturer: Pfizer

Nonproprietary Name: Doxepin HCl (USAN)

Indications: Psychoneurotic anxiety and/or depressive reactions.

Contraindications: Hypersensitivity to the drug, glaucoma or a tendency to urinary retention.

Dosage: Usual optimum dose range is 75-150 mg./day. Individualized.

Supplied: Capsules—10, 25, and 50 mg.

DUPLICATE SINGLE PRODUCTS

ALPEN Penicillin R

Manufacturer: Lederle

Nonproprietary Name: Ampicillin trihydrate

Indications: Infections due to susceptible strains of Gram negative and Gram positive bacteria.

Contraindications: History of allergic reactions to penicillins or cephalosporins. Infections caused by penicillinase-producing staphylococci or other penicillinase producing agents.

Dosage: Adults: 250-500 mg./6 hrs.

Children: 50-100 mg./kg./day in divided doses every 6-8 hrs.

Supplied: Capsules—250 and 500 mg.

ALPEN-N Penicillin R

Manufacturer: Lederle

Nonproprietary Name: Sodium ampicillin

Indications: Infections due to susceptible strains of Gram negative and Gram positive bacteria.

Contraindications: History of allergic reactions to penicillins or cephalosporins. Infections caused by penicillinase-producing staphylococci or other penicillinase producing agents.

Dosage: i.m. or i.v.

Children: 12.5 mg./kg./6 hrs.

Adults: 250-500 mg./6 hrs.

Supplied: Vials—250, 500 and 1,000 mg.

PAREST Hypnotic R

Manufacturer: Parke-Davis

Nonproprietary Name: Methaqualone hydrochloride

Indications: Insomnia

Contraindications: Pregnancy or possible pregnancy, concomitant use of psychotropic drugs or other central nervous system depressants.

Do not use in patients under 14 years of age.

Dosage: 200 or 400 mg. taken 15-30 min. before retiring.

Supplied: Capsules—200 mg.

VAGESTROL Hormones—Estrogens R

Manufacturer: Eaton

Nonproprietary Name: Diethylstilbestrol (USP)

Indications: Local treatment of atrophic or senile vaginitis, atrophic vulvovaginitis and cervicitis associated with hypoestrogenic conditions.

Contraindications: Malignancy or precancerous lesions of breast, vagina or vulva. Sensitivity to the drug or undiagnosed vaginal bleeding.

Dosage: Insert suppository into vagina in morning and at bedtime for 12 days after which dosage may be adjusted in accordance with patient response.

Supplied: Suppositories—0.25 mg.

COMBINATION PRODUCTS

CO-TYLENOL Cold Preparation o-t-c

Manufacturer: McNeil

Composition: Each tablet contains:

Acetaminophen 325 mg.

Chlorpheniramine maleate 1 mg.

Phenylephrine HCl 5 mg.

(Continued on page 96)

ON THE COVER

Our cover depiction of a file folder should bring to mind the many records maintained about everything we accomplish. Many of these records are essential in the areas of peer review and malpractice litigation. To hear more about these two areas of concern and to learn about safeguards every physician should accomplish, a special seminar will be conducted Sunday, February 8, at the Sheraton-Blackstone Hotel, Chicago. This will be the 1970 Leadership Conference.

All ISMS members are encouraged, better—urged, to be present. The sessions will be informative and have been planned to be extremely useful. A special report on page 44 gives further particulars.

A New Insight For The

Gastrointestinal Surgeon

By JACK H. SANDERS, M.D., F.A.C.S./CHICAGO

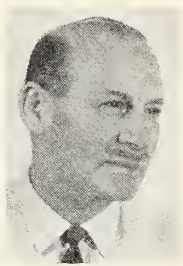
With the introduction of flexible fiberoptic endoscopes to clinical medicine, an important diagnostic tool has been made available to the general surgeon. These bendable optical instruments with photographic attachments can be introduced with less hazard and considerably less discomfort to the patient than the older, semi-rigid scopes with lens systems. Because the patient's head and neck are not held uncomfortably in fixed extension, the procedure is not hurried and mucosal visualization is more thorough.

The marvel of fiberoptics is based on the complete inner reflection of light through fine glass flexible fibers having an outer coating. Thousands of these fine fibers are bundled together which permit the transmission of light entering at one end to emanate at the other, although the

bundle itself may be bent in a complete circle. Because of the distance from the hot light source, the transmitted light is "cool." This same light, illuminating an object or mucosal surface, may be returned as an image through other parallel bundles of fibers to be visualized or photographed. During these past few years, considerable improvement has been made in the optical fidelity of these fiber bundles and the directional control of the instrument tips. Miniaturized cameras and high intensity strobe lights, coupled with sensitive color film, now permit accurate simultaneous color photographic documentation of the mucosa that is visualized. Significantly, the "cool" light emanating from the end of the instrument does not cause tissue injury or patient discomfort. In some instruments, parallel hollow channels adjacent to the light bundles permit biopsy of the mucosa under direct vision. Similarly, "Paps" specimens may be obtained by directing jets of water at suspicious lesions which can be retrieved through these same channels.

I do not wish to intimate that these instruments can be used without training and considerable experience. The hazards of perforation and hemorrhage are ever present and are not to be dismissed casually because of the instrument's flexibility. I do believe that training should start early in the surgical residency. It

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would seem logical that the surgical trainee who is taught to evaluate mucosal pathology grossly and microscopically should also be taught to evaluate it through an endoscope.

The following clinical conditions will serve to illustrate situations in which the author has found the fiberoptic endoscopes to be of firm clinical value:

In upper gastrointestinal hemorrhage, following the evacuation of clots with an Ewald tube, and ice water lavage, esophageal or gastric varices have readily been visualized. Similarly, a bleeding gastric ulcer or diffuse mucosal hemorrhage from an acute gastritis and upper gastric mucosal tears has been seen. Under these similar circumstances, a normal esophago-gastric mucosa indicated that the bleeding source was distal to the pyloric sphincter. On one occasion, blood was seen regurgitating through the pyloric canal.

A malignant gastric ulcer visualized on X-ray has been confirmed on direct visualization, or unquestionably confirmed with positive biopsy. A negative biopsy, however, does not have much significance.

A positive biopsy of a malignant lesion through an endoscope has avoided the spillage of open biopsy via a gastrotomy incision at the time of surgery. Some surgeons, who are routinely preoperatively gastroscoping the stomach, have been finding a higher incidence of superficial gastric ulcers, benign polyps and pancreatic ectopic tissue unsuspected radiologically.

On one occasion, a black silk suture was seen protruding through the mucosa at the anastomotic stoma into the lumen of the stomach.

I have found that the follow-up of an alleged "benign gastric ulcer" to complete healing or further ulceration to be of first hand value in deciding continued conservative treatment or surgical intervention.

The fundus of the stomach, which has always been a diagnostic challenge to the radiologist, can almost always be visualized from below. This has contributed to the differentiation of Mentrrier's Disease, and lymphomata, and hypertrophied gastric rugae.

The flexible fiberoptic esophagoscope with the "cool" light has permitted more comfortable diagnosis of reflux esophagitis, esophageal tumors and strictures.

As a surgeon, I now realize the validity of drug induced gastritis and that it can cause severe gastric hemorrhage. Similarly, I have found that "superficial gastritis" is truly a clinical entity.

And so, modern technology has now given us instruments that make an old diagnostic procedure more comfortable, less hazardous and more practical. This has widened the field to include the elderly and acutely ill patient, and has made a second or follow-up examination more readily accepted by the patient.

Instrument flexibility and directional control of the working optical tip has decreased blind spots to a minimum, and permits visualization of mucosal surface pathology not suggested by radio opaque barium resting on that surface.

A new insight has been given to the gastro-intestinal surgeon. ◀

Journeyman Wages

Labor leaders, often critical of MDs' incomes, are not likely to point out that under New York construction contracts a sheet-metal worker could earn \$51,802 a year if he worked as long as average MD, about 60 hours a week. Even with month's vacation he could earn \$49,458. Carpenter could earn \$48,973. New contract calls for 50% increase for sheet-metal workers over next 3 years (up to \$11.72 an hour, or \$23.44 an hour for overtime). Carpenters will earn \$11.08 an hour; after 35 hours, overtime pay will be \$22.16. (*Medical News Report* 1:10 [Nov. 17] 1969.)

Management of

Severe Status Asthmaticus

BY ANTHONY D. IVANKOVIC, M.D. AND CHRISTEN C. RATTENBORG, M.D./CHICAGO

The danger to life of status asthmaticus is slight today because treatment with bronchodilators, corticosteroids and aminophylline is adequate to terminate such attacks in most instances. However, a small group of patients fails to respond to all therapeutic measures and mortality of this group is considerable.¹⁻³ This mortality could be significantly reduced by a better understanding of physiological events and newer means of therapy and resuscitation.



Anthony D. Ivankovic, M.D., (left) is clinical instructor, department of anesthesiology, University of Chicago. A graduate of the Medical School Zagreb, Yugoslavia, Dr. Ivankovic served his internship at Edgewater Hospital, Chicago, and his residency in anesthesiology at the University of Chicago Hospitals. In addition, he spent two years in cardiac specialization in Nurnberg, West Germany. Christen C. Rattenborg, M.D., is a graduate of the University of Copenhagen, and is associate professor with the department of anesthesiology, University of Chicago. He is a member of the American Board of Anesthesiology and the American Society of Anesthesiologists.

Case Report

A 31-year-old woman was admitted to the hospital with diagnosis of severe status asthmaticus. She was known to have had asthma for 12 years with several previous hospitalizations for status asthmaticus. She had numerous minor attacks and during the last five years she used Isuprel Misto-meter almost daily.

Physical examination showed an apprehensive, agitated, obese woman with labored ventilation with the use of auxiliary respiratory muscles and massive dry expiratory wheezing over both lungs. X-ray showed a patchy infiltrate in the right base—suggestive of right middle lobe pneumonia. WBC was 12,000.

For 12 hours the patient was intensively treated with mild sedation, Robitussin, Aminophylline, Epinephrine, Isuprel and steroids intravenously, and with IPPB with Isuprel nebulizer. Despite this intensive drug therapy, the respiratory and circulatory functions gradually deteriorated. When the anesthesiologist was notified, the patient was extremely cyanotic and comatose, BP was 80/50 and pulse rate 180/min.

Ether anesthesia with 100% O₂ was tried to terminate the attack. The patient was induced with ether and halothane by mask and intubated after relaxation with 60 mg. of Succinyl choline intravenously. Only a small amount of very thick mucus was obtained by suctioning. An inflation pressure of 70 cm of water was required to move

an adequate tidal volume. The patient was brought to plane III and IV, the pupils dilated, the intercostal muscles were paralyzed, the diaphragmatic jerks caused tracheal tug. In spite of this, a wheezing and a very tight chest remained, but the color of the patient improved significantly. One hour after ether administration with 100% O₂ and 500 cc Na Bicarbonate intravenously, the PaO₂ was 400, PaCO₂ was 66 and pH_a was 7.39.

During the emergence from anesthesia, the persistent wheezing made it evident that the patient's attack was not relieved. An attempt to manage the condition with Halothane in 100% O₂ was equally unsuccessful.

It was decided to keep the patient heavily sedated during assisted ventilation with a Bird respirator which required a maximal pressure of 60 cm H₂O. Sedation was achieved with Demerol-50 mg and Thorazine-25 mg, administered alternately every two hours intramuscularly. The Demerol-Thorazine combination also supplied a ganglionic blockade. To achieve necessary muscle relaxation, d-Tubocurarine-18 mg was administered intravenously followed by 6 mg intramuscular q 45 min. for several hours. The next three days, the patient received additional Aminophylline, steroids and Penicillin. On the second day, wheezing decreased and large amounts of mucoid sputum almost poured into the bronchial system and were easily and continuously aspirated. PaO₂ was maintained between 117-139 mm Hg, PaCO₂-32-38 mm Hg and pH-7.46-7.52 by artificial ventilation with 30% O₂ with a Bird ventilator with maximal inflation pressures of 25-30 cm H₂O.

On the third day the wheezing disappeared completely and the patient was able to maintain normal blood gases by spontaneous respiration; the controlled respiration was discontinued and the endotracheal tube was removed. The patient had retrograde amnesia for all events from a few hours after admission until the third day when Demerol-Thorazine were discontinued. Her condition continued to improve and she was discharged on the eighth hospital day without any symptoms of asthma.

Discussion

During an asthmatic attack, broncho-

constriction, bronchial mucosal edema and tenacious secretion result in significantly increased airway resistance. Expiratory obstruction is greater than inspiratory obstruction, primarily because the pathological constriction due to disease is superimposed upon the normal expiratory narrowing. This results in overdistention of the lungs and further contributes to the restriction of airflow. The inspiratory flow does not start until the airway pressure is higher than elastic recoil pressure, which is due to increased FRC, caused by air trapping. There is, therefore, markedly increased work of breathing, but only partly due to increased airway resistance. However, mechanical efficiency of breathing decreases despite the exaggerated muscular effort, and respiratory failure develops. Death is probably due to respiratory center failure, although cardiac arrest is not uncommon and seems to be caused by a combination of hypoxia and impaired pulmonary circulation due to pulmonary vasospasm (secondary to hypoxia and acidosis) and increased intrathoracic pressure.

An increase in ventilation and decrease in FRC is the key to correction of the pathophysiologic imbalance of status asthmaticus. The principle of this method is a mechanical one—the application of controlled ventilation by intermittent positive pressure. The airway is easily provided by a cuffed endotracheal tube. An oroendotracheal tube is often tolerated for several days and provides an acceptable means of cleaning secretions and application of ventilators for total support. Tracheostomy should be deferred until it is clear that prolonged, continuous care is necessary.¹⁶

General anesthesia had been used to terminate status asthmaticus when the other forms of therapy failed, especially diethyl ether, well known as a bronchodilator agent which has enjoyed widespread popularity.⁴⁻⁷ However, the results have not always been satisfactory.⁸ Maintenance of deep anesthesia with ether could be hazardous for the asthmatic, as ether can induce severe circulatory depression in these labile patients. Halothane⁸ has been found superior to ether, but its ability to dilate bronchi has not been established and it is incompatible with sympathomimetic bronchodilators.

The traditional fear of narcotics^{9,15,16} is

not warranted as long as an automatic lung ventilator is used. Under these circumstances, depression of the respiratory center or musculature becomes an advantage. Curare is said to cause asthma through its release of histamine, so it may be contraindicated in the asthmatic;¹⁰ but it has, however, successfully been used by others⁸ and by us.

Although bronchial asthma is a complex disease, in the terminal phase, probably, the mechanical problem is overwhelming.

The management of terminal status asthmaticus by mechanical ventilation of the lungs converts this lethal condition into one that should resolve itself within a day or two of intensive treatment.¹¹⁻¹² Ideally, the patient should be treated by an anesthesiologist or other competent physician able to care for emergency airway problems and ventilation equipment.¹¹⁻¹⁴ Moreover, in recent years, an organized team-approach has emerged and acute respiratory care units have been established at some hospitals, providing further contribution to treatment of the acute respiratory failure. ◀

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Senator Ralph Smith to Speak at ISMS Public Affairs Banquet, May 18, 1970

Senator Ralph Smith will be the principal speaker at the 1970 Annual Public Affairs Banquet of the Illinois State Medical Society, scheduled May 18.

The meeting will be held in Chicago's Sherman House in conjunction with the Annual Convention of the Illinois State Medical Society, May 17-20, 1970.

The Annual Public Affairs Banquet is a highlight of the Convention. Theodore Grevas, M.D., Chairman, ISMS Public Affairs Committee said, in announcing the banquet, "We are most pleased that Senator Smith has included our important event on his busy 1970 calendar. We want as many physicians and wives to become acquainted with Senator Smith as possible and special arrangements will be made prior to the Banquet so that everyone

will have an opportunity to talk with the Senator."

Senator Smith, soon after his appointment by Governor Ogilvie, was placed on two important Senate committees, including the Senate Labor and Public Welfare Committee which handles much of the key medical and health related legislation that is introduced into the Senate, and the Space and Aeronautical Sciences Committee. He serves on the Health Subcommittee of the Senate Labor and Public Welfare Committee. As a result, Senator Smith becomes one of the key Senators with whom medicine must work as medical legislation progresses through the U.S. Congress.

Mark the date of May 18, 1970 on your calendar and plan to attend this popular banquet program.

Raising Brighter Children

BY ARTHUR L. ENNIS, M.D./DECATUR

The human offspring will learn the most and the fastest from the time of his birth to the time he goes to school.

I believe the new baby's *mental* development is vitally important as well as his physical development. The baby's doctor has the opportunity, privilege, and perhaps responsibility of giving the new parents suggestions and advice in developing the baby's mind as well as his body.

Caring for the new well baby is a happy experience for both parents and doctor, and the observations of their mental development make it even more fun. For me an added incentive for infant education is my three grandchildren.

Joan Beck says in her book, *How to RAISE A BRIGHTER CHILD*, "Your child does not have a fixed intelligence or pre-determined rate of intellectual growth, contrary to such widespread opinion in the past. His level of intelligence can be changed—for better or worse—by his environment and especially during the earliest years of his life. Because behavioral scientists assumed in the past that intelligence was a fixed quality, they were not searching for ways to increase the intellectual abilities of children."¹

Mrs. Beck also says, "Once you accept the theory that a child's intelligence can change, and that it can be lowered by lack of stimulation during the earliest years of life, the next obvious question is: What happens if you deliberately enrich a youngsters environment with intriguing stimulation? If eight weeks in a summer Head Start Class can raise a four year old's I.Q. from 6 to 14 points, what could be done if the youngsters were given a loving, deliberately stimulating environment from birth on."²

Nearly all geniuses, it has been found, have had an exceptional home environment and teacher in the first years of life. Also, children brought up in orphanages where they have very little mental stimulation, have had a large proportion of low I.Q.s. This has depended on the degree of stimulation they have had.³

The Montessori Concept

Dr. Montessori over 60 years ago discovered that intelligence is not fixed.⁴ She had her child care classes in the poorer slum parts of Rome. Most of her pupils became greatly advanced in their learning over the ones in the better parts of the city. The first English translation of her work was in 1912. The second printing was 1964, and since then there have been three more printings. Her concepts of education of the very young have been re-discovered in the past few years. There are Montessori like classes scattered over the entire United States.

How, then, can we doctors help the young parents to stimulate their offspring mentally? The mother is the main early teacher as she is with her baby the most. We can suggest to her that she develop each of the baby's five senses: seeing, hearing, feeling, tasting, and smelling.

A newborn's education starts the day he is born. At first he does not care much about his environment as long as he is

Arthur L. Ennis, M.D., is a Decatur general practitioner and general surgeon. A graduate of the University of Illinois Medical School, Dr. Ennis is a Fellow of the American College of Surgeons. In addition, he holds a Master's Degree in Medical Science (Surgery) from the University of Pennsylvania Graduate School.



comfortable and has a full stomach. However, he soon starts to notice things. Color and movement catch his attention. Mobiles of fish, birds, or butterflies, balloons, and colored pictures on the walls make young ones more aware of their surroundings. The worst thing that can be done is to put him in a basket or crib lined with white. He would get no visual mental stimulus.

Hearing is developed when the mother talks to her baby. This can be done each time she cares for him. This is the way he learns words and identifies objects. She can tell him she is putting his right arm in his blue shirt sleeve, his left leg in his rubber pants, or that she is washing his right foot, his mouth or his ears. Feeling, smelling, and tasting can be investigated and enjoyed in a similar manner. It should always be *fun* and enjoyable for both mother and baby.

Begin Reading Early

Doman—who is Director of the Institute for Achievement of Human Potential, in Philadelphia—tells of his work with brain damaged children. Many of them were reading by the age of 3 or 4 years. This later led to trying some of his methods on normal children.¹² He used word and object association. The phonic method of reading seems more logical and is preferred by many educators. No matter what the method, word sight or phonics, talking computer typewriter, flash cards, or nursery educators, they are usually successful in teaching the pre-school child to read. It has been consistently shown that early readers do better all the way through their schooling.

Making it fun and enjoyable is the important thing to remember in teaching the young child. Also their attention span is short and variable. They must be cheered, tickled, chased or what ever it takes to make it fun. They must be motivated to play word or learning games. Also, the game must stop while they are still interested so they will want to come back later for more. Flowers, insects, birds, animals and machinery—all are new to a child. Picture books from the library are wonderful.

Professor Suzuki in Japan has taught children to play classical music on the violin by the time they are three-years-old.⁶ From thousands of students, he and his

teachers report no failures. He says, "I must begin before the child is born by teaching the parents."⁶ Children are entered in Suzuki's Class before birth. The parents are taught what attitudes are necessary. They must be convinced that their child will play the violin well at an early age. Suzuki and his staff are. They see the child first after his second birthday. The pre-class training consists of listening to the same classical recordings daily from the time of birth. At age two, they start their class with a mixed group of older children. By the age of three they are playing classical music by ear.⁶

There are three books that I have found to be especially helpful for young parents. They are well written and easy to read. I also recommend them to any Doctor caring for young children. They are: (1) Joan Beck, *HOW TO RAISE A BRIGHTER CHILD*, (2) Richard Gariepy, *YOUR CHILD IS DYING TO LEARN*, (3) Dr. Haim Ginott, *BETWEEN PARENT AND CHILD*. I used to advise young mothers to purchase the books or obtain them at the library, but they were not available so many times that now I carry a supply at my office.

The first book is given to the new mother when she is in the hospital after the new baby arrives. It would be better for her to read it during the pre-natal period, but I have not done this as I do not do obstetrics. The second and third books are read next. The patient is charged the regular price for the book. This is refunded in full when she returns it to the office.

Conclusion

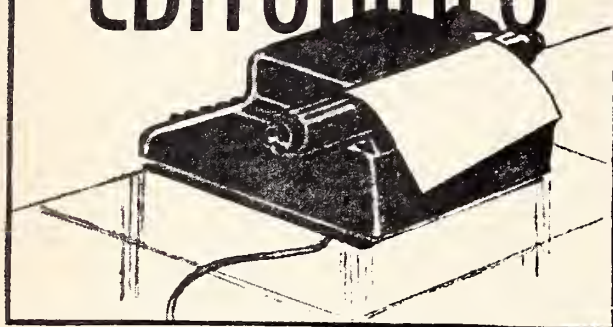
Today's children are bright, but I am sure the children of tomorrow will be even brighter. Mental development, as well as physical development, is important for the pre-school child. The doctors in contact with babies and small children have the privilege, opportunity, and perhaps responsibility in advising the parents in their child's learning process. It also adds interest in caring for the well baby and child. ◀

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(Continued on page 98)

EDITORIALS



THE AIR, THE AIR IS EVERYWHERE

The American Chemical Society (ACS) recently issued a 249-page report covering the results of a 3-year study by more than 100 experts on a possible solution to our pollution problems.¹ They made 73 recommendations to utilize our technical know-how toward attaining a cleaner environment. According to Philip M. Boffey, writing in *Science*,² most of these recommendations are addressed to everyone and thus to no one in particular. In addition, the suggestions for research, development, study, investigation, measurement, and assessment would not bring about an immediate reduction in pollution.

The committee admitted that our appalling lack of knowledge was hampering pollution control efforts. Apparently there are too few "experts" in solid wastes disposal. As a result, it is difficult to decide whether many of the proposed antipollution steps will work. Furthermore, some existing pollution standards have no scientific basis for support.

The report emphasized that the pollution technology in use in this country is obsolete. The technology used to determine air pollution is 10 to 20 years old. The methods used to handle and dispose of sludges in waste water have been known for 40 years. In many instances they are not used and the apathy stems from negligence, not ignorance.

The report also points out that it is difficult to stimulate enthusiasm for pollution control. People complain about detergents that contain algae nutrients such as phosphorus, but none switch to soap.

Many companies hope for a method that will control pollution and at the same time prove financially profitable. This, however, is unlikely. Waiting for this extra dividend only postpones the realization of cleaner lakes and rivers, cleaner country, better health, and less corrosion of electrical and other equipment.

An analysis was also made of the ill effects of pollution on health. The death rate from pesticides has been constant in the United States at one per one million population over a 25-year period. This is surprising, considering the vast increase in pesticide usage. In addition, the researchers found no evidence that prolonged low-level exposure to pesticide residues, such as in the diet or environment, has an undesirable effect on human health. They did admit that there is strong presumptive evidence that pesticide residues are inhibiting the productivity of entire ecosystems. They recommended that pesticides be used "only in minimal amounts and under conditions where they have been shown not to cause widespread contamination of the environment."

As for air pollutants, the report stated that "while typical urban concentrations are not acutely lethal . . . it is difficult to argue that their lesser concentrations make them harmless." They cited evidence that air pollution has damaged plants, rubber, fabrics, dyes, and nylon hose. In addition, they predicted that pollution might get worse because we were not applying existing control technology and that industry continues to grow. The committee recog-

nized that existing standards restricting the exhaust from automobiles will help, but the improvement in the air will be nullified within a few years due to the increase in the number of cars. The report calls for more stringent standards.

The health aspects of water pollution also were debatable because nothing was known of possible adverse effects of a variety of largely unidentified chemical compounds that enter sources of water supply in municipal and industrial wastes, both treated and untreated. They urged greater research on sewage treatment. The report was unable to find a well-defined relation-

ship between solid wastes and human health. The technological methods used to handle and dispose of solid wastes in the United States lag well behind those used to control air and water pollution.

T. R. Van Dellen, M.D.

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Clinics for Crippled Children Scheduled

Twenty-four clinics for Illinois' physically handicapped children have been scheduled for February by the University of Illinois, Division of Services for Crippled Children. Seventeen general clinics will provide diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be five special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Feb. 4—Carlinville—Carlinville Area Hospital
- Feb. 4—Hinsdale—Hinsdale Sanitarium
- Feb. 4—Rock Island Cerebral Palsy—3808 Eighth Avenue
- Feb. 5—Lake County Cardiac—Victory Memorial Hospital
- Feb. 10—Peoria—St. Francis Children's Hospital
- Feb. 10—East St. Louis—Christian Welfare Hospital
- Feb. 11—Champaign-Urbana — McKinley Hospital
- Feb. 12—Rockford—St. Anthony Hospital
- Feb. 12—Springfield General—St. John's Hospital
- Feb. 13—Chicago Heights Cardiac—St. James Hospital
- Feb. 17—Belleville—St. Elizabeth's Hospital
- Feb. 17—Rock Island Area General—Moline Public Hospital

- Feb. 18—Chicago Heights General—St. James Hospital
- Feb. 19—Anna—Union County Hospital
- Feb. 19—Bloomington—St. Joseph Hospital
- Feb. 19—Elmhurst Cardiac—Memorial Hospital of DuPage County
- Feb. 20—Chicago Heights Cardiac—St. James Hospital
- Feb. 23—Peoria Cardiac—St. Francis Children's Hospital
- Feb. 24—Peoria—St. Francis Children's Hospital
- Feb. 24—East St. Louis—Christian Welfare Hospital
- Feb. 24—Danville—Lake View Hospital
- Feb. 25—Aurora—Copley Memorial Hospital
- Feb. 25—Springfield Cerebral Palsy—Diocesan Center
- Feb. 27—Evanston—St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



THE DOCTOR'S LIBRARY

ATLAS OF EAR SURGERY. By William H. Saunders, M.D., and Michael M. Paparella. The C. V. Mosby Co., 1968, 363 pgs., \$27.50.

The authors, in their preface, have indicated that this book is an illustrated guide of technics employed in otologic surgery. This guide is intended for residents or graduates in otolaryngology. As such, discussions of diagnosis, indications for surgery or post-operative management were not included.

This text has come closer to fulfilling the authors' intentions than any other in this reviewer's memory. Primarily of interest to students of ear surgery, the contents are inclusive, the illustrations are clear and accurate, and the text is concise and decisive. The second section of 45 pages devoted to dissection of temporal bone specimen in preparation for the operative sections to follow is a valuable inclusion. The initial section, a chronologic outline of the development of otology, seems extraneous but will be of interest to all students of otology.

The sections on operative procedures are excellent. The outline text and pictures would not carry a neophyte through an operation unassisted but certainly will totally familiarize him with the steps involved with each surgical problem.

All new books have weaknesses and in this instance it is in the section devoted to tympanoplasty. Neither the nomenclature, nor many technics which have been in use in the past few years in this country are described. Rather the original Wullstein-Zollner methods of hearing restoration are used as a classification for this section. The authors have devoted half the space to this area as that to otosclerosis surgery perhaps indicating their opinion as to the "state of the art."

The book is excellent overall and should be a required (and cherished) possession of every otologic student. It could well serve as a teaching guide for their professors. It will be of interest also to interns and physicians in many areas and should become a part of all medical libraries.

David F. Austin, M.D.

THE TREATMENT OF BURNS By Artz, C. P. and Moncrief, J. A., Second Edition, W. B. Saunders Company, Philadelphia, 1969.

It is difficult to think of anyone more qualified to prepare a book devoted to the treatment of burns than the authors of this 393-page volume. Doctor Artz and Doctor Moncrief have contributed a great deal to our understanding of the management of the burn patient over the years, and their extensive knowledge forms a basis of this book.

The first edition of THE TREATMENT OF BURNS was published approximately 10 years ago, and the authors point out that the present volume is entirely a new book.

The magnitude of the burn problem is understood when it is realized that the average number of burn injuries annually is 1,973,000, and that 268,000 are classed as "bed disabling injuries" according to the authors.

The first chapter of this interesting book deals with the burn problems and emphasizes the need for the development of specialized centers for burns.

The second chapter is devoted to pathology of burns and is written by Dr. Carl Teplitz of the Department of Pathology of Boston University.

The chapter on anesthesia for the severely burned patient was prepared by Dr.

Burton S. Epstein, an anesthesiologist at George Washington University School of Medicine, who, like Dr. Teplitz, was formerly a member of the Surgical Research Unit at the Brook Army Medical Center.

The chapter on musculoskeletal changes secondary to burns was written by Dr. E. Burke Evans, Head of the Division of Orthopedic Surgery at the University of Texas Medical Branch in Galveston.

The remaining chapters are the product of the authors and present a comprehensive, concise description of the management of the burn patient from the inception of the burn through the special problems and complications of burns and burn therapy.

The selection of patients for hospitalization is presented.

Initial replacement therapy is the subject of a complete chapter.

The book is well illustrated, with appropriate drawings and photographs, covering the major points in burn treatment. There are even careful details on the use of the dermatome; preparation of impregnated gauze for burn coverage; the use of homografts, and many other specific points that are helpful to the clinician.

This well prepared book should be of great interest to all physicians who manage the burned patient and should be particularly helpful to residents in training who desire a ready reference on the subject.

John M. Beal, M.D.

PEDIATRIC CARDIOLOGY By Hamish Watson, M.D., Editor, C. V. Mosby, St. Louis, 996 Pages.

This book, although a textbook of PEDIATRIC CARDIOLOGY, is in reality an encyclopedia of present day knowledge written by an international group of contributors. Many of the 68 chapters are exceptionally detailed and scholarly, but the work has been well conceived and edited and should be a valuable guide to all types of readers.

Chapters on Cardiac Embryology and Clinical Anatomy of the Heart are models of clarity and detail. Most of the succeeding chapters on specific malformations are unusually well illustrated with diagrams and radiographic and electrocardiographic material. This is an outstanding multi-

author text and should stand as a valuable contribution to the literature on pediatric cardiology.

Milton H. Paul, M.D.

SYMPOSIA ON RECONSTRUCTIVE PLASTIC SURGERY AND ON SURGERY OF THE HAND, Edited by J. M. Converse and M. A. Entin. W. B. Saunders Company, Philadelphia, 1968.

This book is a collection of papers which originally appeared in the *Surgical Clinics of North America*, April 1967, and October 1968, covering Reconstructive Plastic Surgery and Practical Surgery of the Hand. It is an international symposium combined now in one volume and represents some of the world's most active contributions in these fields.

The section on Reconstructive Plastic Surgery is broad in scope, covering basic subjects and techniques of resurfacing operations for hand surgery by Dr. Robert Beasley of New York, and finger extensor mechanism by Dr. J. William Littler also of New York, to advanced information such as Biomedical Properties of Skin, by Mr. Thomas Gibson of Glasgow, and Hematologic Determinants of Histocompatibility, by Dr. Felix Rappaport of New York University. The historical review of the coming of age of plastic surgery by Guest Editor, Dr. John Marquis Converse, is interesting to the student of plastic surgery.

Dr. Martin A. Entin has edited the section on Practical Surgery of the Hand and has assembled considerable talent on this subject. The emphasis is clinical and, as the title suggests, practical. Reconstruction of the Thumb by Dr. Claude Verdan of Lausanne, and Salvaging the Basic Hand, by Dr. Entin, are two superb chapters for students of surgery of the hand. The volume discusses also the latest methods in hand surgery; for example, rubber implant replacement of arthritic or destroyed joints in a chapter by Dr. Alfred Swanson and Associates from Blodgett Memorial Hospital in Grand Rapids, Michigan.

The Saunders Company is to be congratulated for combining and reprinting these symposia which complement each other and for making them generally available.

Peter W. McKinney, M.D.

1970 LEADERSHIP CONFERENCE...

Sunday, February 8

Sheraton-Blackstone, Chicago

- 9:30 a.m. CALL TO ORDER AND OPENING COMMENTS**
Jacob E. Reisch, M.D., Conference Chairman
Illinois State Medical Society
- 9:40 a.m. THE MEDICAL MALPRACTICE SITUATION IN THE U.S.**
Mr. George E. Hall, J.D.
American Medical Association
- 9:55 a.m. THE MEDICAL MALPRACTICE SITUATION IN ILLINOIS
AND WAYS IN WHICH PHYSICIAN LIABILITY CAN
BE LESSENERD**
Mr. Frank M. Pfeifer, Counsel
Illinois State Medical Society
- 10:25 a.m. WAYS IN WHICH HOSPITAL LIABILITY CAN BE LESSENERD**
Mr. Harry Kinser, Counsel
Illinois Hospital Association
- 10:40 a.m. QUESTIONS AND ANSWERS**
- 11:00 a.m. LESSONS TO BE LEARNED FROM MALPRACTICE CASES
DECIDED IN ILLINOIS**
- 11:30 a.m. WHAT ISMS IS ATTEMPTING TO DO**
- 12:15 p.m. LUNCHEON**
Guest Speaker—Jesse L. Steinfeld, M.D.
U. S. Surgeon-General
- 1:30 p.m. PRIVATE HEALTH INSURANCE NEEDS PEER REVIEW**
Louis A. Orsini, Director
Health Insurance Council
- 1:45 p.m. BLUE CROSS-BLUE SHIELD POSITION ON PEER REVIEW**
John C. Troxel, M.D., Senior Vice-President
Medical Department
Blue Shield Plan of Illinois Medical Service
- 2:00 p.m. ILLINOIS PHYSICIANS NEED PEER REVIEW**
Frank J. Jirka, Jr., M.D., Chairman
ISMS Board of Trustees
- 2:15 p.m. EFFECTIVE PEER REVIEW GUIDELINES FOR COUNTY
SOCIETIES**
Fred Z. White, M.D., Chairman
ISMS Council on Economics & Governmental Health Programs
- 2:40 p.m. "HOW TO—PEER REVIEW"**
Panel Discussion
- 4:00 p.m. QUESTIONS AND ANSWERS**
- 4:30 p.m. ADJOURN**

...A "MUST" FOR ALL ISMS MEMBERS

MALPRACTICE

- *What's behind the recent surge in malpractice suits?
- *How can I best protect myself against the malpractice danger?
- *Where can I get help if I anticipate a malpractice suit?
- *Why are some MDs more prone to malpractice suits than others?
- *What is my State Society doing to protect me?

PEER REVIEW

- *Why do we need peer review in Illinois?
 - *How does a peer review committee differ from grievance and utilization review committees?
 - *How is a peer review committee organized?
 - *Are there any "teeth" in peer review?
 - *What's ISMS doing about establishing effective peer review in Illinois?
-

These are only a few of the many problems that will be explored in depth at the Illinois State Medical Society's 1970 Leadership Conference to be held Sunday, February 8, at the Sheraton-Blackstone Hotel in Chicago.

Open to ISMS members only, the Leadership Conference will spotlight the two most critical issues facing physicians today—malpractice and peer review. (See program agenda on facing page.)

Conference Chairman Dr. Jacob E. Reisch reports that the morning Malpractice Seminar will open with a "Situation Report" by ISMS legal counsel Frank Pfeifer and George E. Hall from the AMA general counsel's office. Their presentations will bring the *malpractice* dilemma into sharp focus, as it exists within Illinois and on the national level.

The second phase of the malpractice program explores such questions as: "Ways In Which Hospital Liability Can Be Lessened;" and "Lessons To Be Learned From Malpractice Cases Decided in Illinois."

Dr. Clinton L. Compere, a member of the ISMS Medical-Legal Council, will conclude the session with a discussion on ISMS plans for combating the malpractice crisis. He will report on recent policy decisions, legislative possibilities in 1970, the importance of cooperation with hospitals, and the value of county society programs.

Dr. Reisch gave assurance that Conference participants would be given ample opportunity for questions and discussion of malpractice problems.

The afternoon program of the Leadership Conference will be devoted to the equally important and complex topic of *Peer Review*.

Conference luncheon speaker, Dr. Jesse L. Steinfeld, U. S. Surgeon-General, will discuss why government health programs need peer review. Mr. Louis A. Orsini, director, Health Insurance Council, will

present reasons why private health insurance needs peer review; and Dr. John C. Troxel, senior vice-president, Medical Department, Blue Shield Plan of Illinois Medical Service, will speak on why his organization needs peer review.

Highlighting this session, according to Dr. Reisch, will be the unveiling of Guidelines for establishing effective peer review at the county society level. The Guidelines were prepared by ISMS' Council on Economics and Governmental Health Programs.

This highly controversial program will explore methods for developing peer review activities responsive to needs of all parties concerned with the delivery and financing of quality health care: patients, physicians, third party financing organizations and public agencies.

A panel of experts from several areas of Illinois will then respond to peer review problems posed by representatives from medicare, medicaid, public health officials, hospital administrators, government agencies and several commercial health insurance carriers.

Conference participants will again have an opportunity for questions. Answers will be available for such problems as: how does a peer review committee differ from existing grievance, mediation or utilization committees? Is prior acceptance of peer review by hospital, government, and insurance carriers necessary? How is a county peer review committee established? In a small county society, how many doctors must be on a peer review committee? What is the liability of peer review committee members? How are they protected? What about MDs who refuse to accept peer review? Why should the existence of peer review committees be publicized? Why is there a need for peer review procedural standardization throughout the state?

ISMS officers and board members are urging the widest possible participation in this most important program. ISMS members are reminded that their financial and professional futures are in jeopardy unless the malpractice and peer review crises are met and challenged.

If you plan to attend, please complete and return the registration form below.

Complete and return even if you have previously registered.

ISMS Leadership Conference, 360 N. Michigan Ave., Chicago, 60601

I will attend the 1970 Leadership Conference on Sunday, February 8, at the Sheraton-Blackstone Hotel in Chicago.

Enclosed is my check for to cover luncheon(s) (\$5.00 each)

Name.....

Address..... City..... Zip.....

County Medical Society.....



II MJ

**SURGICAL
GRAND
ROUNDS**

Adrenal Neoplasm

EDITED BY JOHN M. BEAL, M.D.



Fig. 1. Film of abdomen from 1967 study of the colon is normal.

Fig. 2. Calcification in the right suprarenal area was detected in November 1968. Both calyceal systems were normal.



Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on May 24, 1969.

Case Report

Dr. John E. Madsen, Jr.: The patient is a 60-year-old woman who was admitted to Chicago Wesley Memorial Hospital in April of 1969 with a chief complaint of right-sided pain. She indicated that the pain was located along the right costal margin and extending posteriorly to the vertebral area. For the past year she had progressive increase in fatigue. She also had palpitation and polyuria and noted a loss of scalp hair. She thought that her weight had shifted from the extremities to the trunk. She complained of frequent throbbing headaches which involved the entire head and over the past 2 years thought that her voice had become deeper in pitch.

Physical examination: she was found to have truncal obesity, blood pressure 200/-80. She had noticeable thinning of scalp hair. Her skin was thought to be thinner than normal and she had multiple hyper-

pigmented 1 to 4 mm macules over the dorsal aspect of her extremities and back. One plus pretibial pitting edema was present. Laboratory studies included blood count and urinalysis within normal limits. The sedimentation rate was elevated to 40. Serum potassium was 2.8 mEq/l and serum bicarbonate was 31 mEq/l. She had an abnormal glucose tolerance test. In addition to X-ray studies, urinary excretion of 17-ketosteroids, and 17-ketogenic steroids and aldosterone was determined. The effect of ACTH stimulation and dexamethasone suppression was assayed and will be discussed by Dr. Lestina. Because of the X-ray findings and adrenal function studies it was felt that the patient had a carcinoma of the right adrenal gland. The patient was operated upon by Dr. George Bulkley April 17, 1969.

Dr. Abram H. Cannon: A film of the abdomen taken at the time of a colon study in 1967 is normal (Fig. 1). However, at the time of a urogram done in November of 1968, there was an irregular calcification in the right upper quadrant (Fig. 2). The calyces and pelvis of the kidneys are normal. The kidneys and the irregular calcification were further studied with a nephrotomogram. Both calyceal systems were found to be normal and the calcification was seen to be in the right suprarenal area. In April urographic and nephrotomographic studies were repeated. The calcification above the right kidney has increased in size and there is an associated mass (Fig. 3). Minor distortion of the kidney outline has occurred.

Dr. John M. Beal: Dr. Frederic Lestina will discuss the diagnostic aspects.

Dr. Frederic A. Lestina: This case emphasizes the difficulty that may be encountered in arriving at an early diagnosis in some patients suspected of having Cushing's syndrome. This patient, formerly normotensive, developed hypertension and also complained of pain in the right flank and right subcostal area. Because of the persistence of the pain and hypertension she was admitted to the hospital. The possibility of an endocrine or metabolic disease was suggested by persistent hypokalemia. We first thought of an aldosterone secreting tumor. Baseline studies were undertaken and the initial urinary excretion of 17-ketosteroids and 17-ketogenic steroids

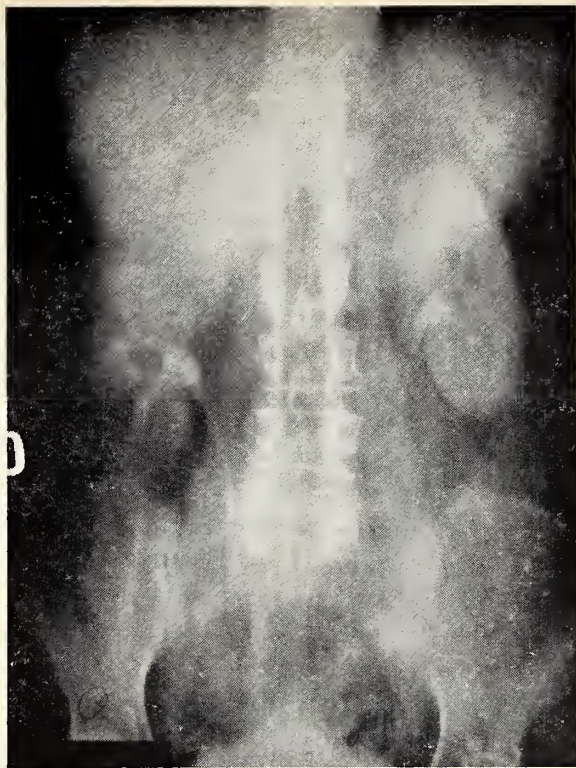


Fig. 3. Suprarenal mass was detected when nephrotomogram was performed in April 1969.

was within normal range. In addition the aldosterone secretion while on a high sodium intake was in a normal range also. Therefore the presence of aldosterone secreting tumor seemed unlikely. The patient continued to complain of pain and further studies were performed. At this point I want to emphasize the importance of careful baseline studies when steroid excretion is being assessed. If an ACTH stimulation test or a dexamethasone suppression test is done, you should always have a baseline study for reference. Baseline studies must cover a number of days because there is a considerable amount of daily and individual variation in the steroid secretion of both normal individuals and those that have adrenal pathology. It is imperative that the patient must not be receiving medication during the test period. The number of drugs that alter the 17-ketosteroids and 17-ketogenic steroid urinary excretion is increasing. Common drugs such as Darvon compound and tranquilizers that we use frequently will alter steroid levels.

In this patient, repetition of the baseline studies of steroid excretion revealed an elevation of both 17-ketosteroids and 17-ketogenic steroids. Therefore, an ACTH stimulation test was performed. Normally ACTH stimulation produces doubling of

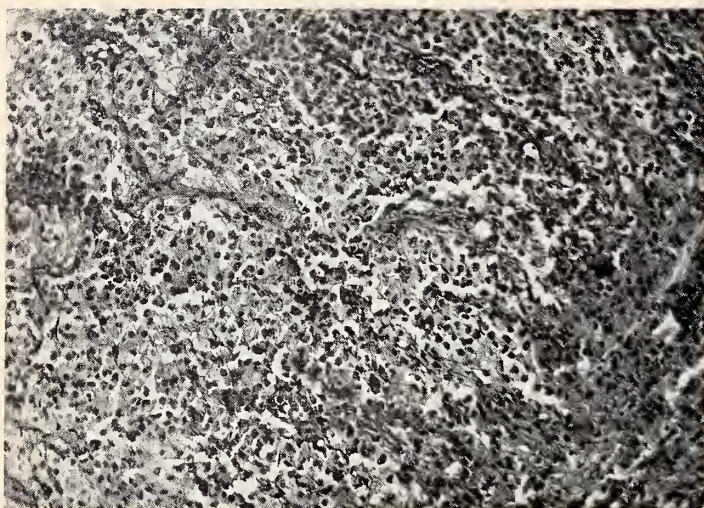


Fig. 4. Histologic study of adrenal neoplasm demonstrates pleomorphism and numerous mitotic figures.

tripling of the daily steroid excretions, but in this patient there was no significant change. A metyrapone test was performed next. Metyrapone is the common compound which inhibits the hydrolysis at the 11th carbon position and demonstrates whether or not the pituitary and adrenal axis is intact. In this patient, administration of metyrapone failed to alter steroid excretion. Therefore a dexamethasone suppression test was performed. The dexamethasone suppression method was originated by Liddle and it has been found to be a reliable technique to demonstrate abnormal adrenal pathology and to differentiate normal adrenal cortical activity, tumor and hyperplasia. In patients with hyperplasia 2 mg of dexamethasone for two days or .5 mg a day every 6 hours for 48 hours results in suppression of steroid secretion. If suppression does not occur a higher dose of 8 mg every 24 hours is instituted. If the hyperactivity is due to a cortical adenoma suppression may or may not be observed. If the hypersecretion is due to carcinoma, suppression does not occur. In this patient dexamethasone suppression at both dosages did not provide an appropriate response and provided further evidence that the patient had an autonomous tumor.

The suprarenal calcification is a significant finding that deserves comment. Approximately 40% of carcinomas of the adrenal cortex contain calcification. Actually carcinoma of the adrenal gland is uncommon and actually only about 140 to 150 cases have been reported. There are several aspects which make diagnosis diffi-

cult. The metabolic manifestations of the tumor are erratic and unpredictable. The tumor often manifests its presence with pain which is often a late manifestation. Usually the diagnosis is not made until approximately 9 months have elapsed from the onset of symptoms. Prognosis is usually poor. In my experience and from a study of published cases, I have found that metastasis occurs quite early. In those instances in which metastases are found at the time of tumor removal the life expectancy is about 2 years. We now have a drug available, o,p'DDD, which is being used in the treatment of inoperable adrenal carcinoma and in those with metastases. With doses up to 10 gm per day there has been a response in approximately 50% and in some instances longevity has been increased to 4 to 5 years.

Dr. Beal: Dr. Bulkley, will you tell us about the operative findings and your surgical approach to the adrenal?

Dr. George J. Bulkley: In considering the surgical approach to this patient's tumor it was not necessary to expose both adrenals and therefore we could attack it directly through the flank. In instances of pheochromocytoma, aldosterone producing tumors or adrenal hyperplasia we prefer to expose both adrenals simultaneously so that we can make a decision as to which course to take during surgery. The original bilateral approach to the adrenal was through the back with the patient prone. This was first done by Dr. Hugh Young and is still used today with good exposure in some patients.

We usually prefer to use the transperitoneal approach in most instances of bilateral adrenal disease and this gives excellent exposure of the entire retroperitoneal area. The case discussed today presented with a large high-lying tumor mass which we knew would require good exposure for complete removal and for this reason we chose to go through the bed of the 11th rib. I reflected the pleura upward and cut the diaphragm posteriorly allowing the tumor to present in the center of the wound. The dissection of the area was quite simple once we had achieved this exposure. The tumor was large but well encapsulated and there was no gross evidence of extension into the kidney or into the surrounding tissues. The mass was somewhat adherent to the upper pole of

the kidney and caused a pressure defect of the kidney but separated readily by blunt dissection. Palpable metastatic deposits were not present in the regional lymphatics. The blood supply to the tumor came chiefly from the renal artery which is not unusual. The blood supply to the adrenal is variable and multiple and when the tumor grows one of the arterial branches grows with it.

In this case it was the branch from the renal artery which we were able to ligate without damage to the main renal artery. The tumor was removed after we isolated the vein which arose directly from the vena cava. The pleura was opened during the initial dissection of the tumor and this opening was closed immediately without chest tube drainage and without pneumothorax. The postoperative course was complicated by slight purulent drainage from the wound which subsided after about 10 days. The wound is now well healed and there were no other postoperative problems.

Dr. Kenneth A. Schneider: This tumor was quite large, measured 15 x 8 x 6 cm, and weighed 470 gm. On the surface of the tumor were several distended venous channels.

One of the problems in discussing tumors like this is whether they are benign or malignant according to their histologic features. This may be one of the reasons why there are discrepancies in survival rates for adrenal neoplasms. Endocrine glands respond to hormones with resulting growth and growth in an endocrine organ produces two changes which are associated with malignancy: pleomorphism and mitotic figures. Thus two of the indices of malignancy do not apply. The sections from this tumor show marked variations in size of these nuclei and they vary in their nuclear staining quality (Fig. 4). There are numerous mitotic figures. Another criterion of malignancy is invasion of the surrounding structures. Adrenal tissue normally is not well contained within the capsule and little islands of adrenal tissue can occur in the periadrenal fatty tissue. Therefore, the detection of cells in fat tissue is not sufficient to establish a diagnosis of malignancy. Therefore, the histopathologic classification of malignancy in adrenal tumors may become very diffi-

cult. Some have said that any tumor over 10 cm in diameter is malignant. This tumor would qualify on the basis of that rule. However, I think the most reliable criterion of malignancy is vascular invasion. Careful study of sections from the tumor revealed that in some places the entire wall of vessels was replaced by tumor. In some of the venous channels, it was possible to find showers of tumor cells. This is objective histologic evidence of malignancy in this lesion. Therefore a diagnosis of carcinoma of the adrenal gland was made.

Dr. Beal: Thank you, Dr. Schneider. This patient illustrates the number of important points. Dr. Lestina has emphasized the failure of this patient to respond to ACTH stimulation or to have a decrease in urinary steroid excretion with the dexamethasone suppression test which is characteristic of carcinoma of the adrenal. This patient had a wound infection. Patients with Cushing's disease and patients after adrenalectomy seem to be more susceptible to infection. Dr. Lestina, will you comment on the postoperative steroid management of this patient.

Dr. Lestina: This patient represented an interesting problem in the postoperative management. The preparation of a patient for removal of an adrenal tumor is the same as that required for bilateral adrenalectomy. When a tumor of this size is present on one side, you can assume that the contralateral gland is atrophic. With that assumption in this case, the patient was prepared by administration of cortisone the night before the operation and again on the day of operation as if she were undergoing a bilateral adrenalectomy. During the ensuing 10 days after operation, the steroid therapy was progressively diminished. As soon as the steroids had been discontinued further baseline studies were carried out. Interestingly enough her 17-ketosteroid excretion was 2.6 mg/24 hrs. in comparison to approximately 39 mg before operation which suggests atrophy of the remaining adrenal gland.

It has been demonstrated that these patients go through a period of adrenal insufficiency after they have recovered from operation. It is advisable to maintain them on small doses of steroids, 25-50 mg of cor-

(Continued on page 98)



By LEON LOVE, M.D

*Director, Department of Radiology, Loyola University Hospital
and Chairman, Department of Radiology, Loyola University
Stritch School of Medicine*



Fig. 1



Fig. 2

This 24 year old white male entered with a history of vomiting, obstipation and crampy abdominal pain of two days duration. He had been operated three times for intestinal obstruction and lysis of adhesions since the age of 3.

Physical Examination:

There was moderate abdominal distension with high-pitched bowel sounds present.

What's your diagnosis?

1. Morquio's Syndrome
2. Poliomyelitis
3. Radiation Changes
4. Hurler's Syndrome

(Answer on page 82)



Fig. 3



Membership Forum

More on Ambulances

Gentlemen:

Your editorial on page 567 of your November *Journal*, relating to improved transportation of accident victims, initialed by "J.G.R.", is absolutely wrong concerning Chicago.

The Chicago Fire Department Ambulance Service is probably one of the best as far as coverage is concerned. The ambulances are manned by Chicago Firefighters well trained in First Aid at our Fire Academy, under supervision of myself and Captain Maker. Our members receive refresher courses in handling patients carefully and thoroughly several times yearly. Also, we have finished our 9th Seminar in care of the acutely ill and severe injuries, sponsored by the Trauma Committee of the American College of Surgeons.

May we suggest that you take time out to find where and how the outstanding Chicago Fire Department Ambulance service serves Chicago with 25 ambulances, 24 hours daily. In my opinion it is and has been doing service to Chicago for the past years, and very efficiently. In fact, our Chicago Hospitals are happy when one of our ambulances arrive at the emergency room with a patient or patients, well cared for at the site of accident, and with proper immobilization of possible bony involvement.

Your inspection of our outstanding Fire Academy, also our Ambulance Service, is requested.

Respectfully,
Harold P. Sullivan, M.D.
Department Physician

Ed. note: Membership Forum is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.

Why Not?

Dear Sir:

It seems ironic to me that at a time when a small town hangs banners to advertise for a physician, more attention isn't directed to the medical student.

In a medical school environment, general practice or family practice receives no support; in fact, it is often de-emphasized. In the first years of medical school the students are especially interested in seeing all kinds of medicine, but in their four years of training, they see every facet of medicine, except family practice or general practice.

There are students interested in this kind of medicine and would like to see it in action and hear it discussed among the physicians. Why aren't medical students personally contacted about seeing and learning this type of medicine?

I'm sure that many of us would appreciate invitations to attend occasional meetings of the Academy of General Practice or down-state county medical societies where we would have an opportunity to meet men in general practice.

Sincerely,
Michael Youssi
University of Illinois
College of Medicine
2nd Year

Narcotics Addicts

It is time again to suggest a solution to the problem of narcotics addiction, particularly since the President recently urged a relaxation of restrictive laws in order to treat the poor narcotics victim with compassion.

The idea is to certify the narcotics addict, then treat him medically and supply him with narcotics to satisfy his needs. This would stamp out an important source of the Mafia's income, virtually eliminate the violence and lawlessness caused by the addict's expensive habit, and allow these people to pursue normal and useful lives.

(From the "Voice of the People" of the *Chicago Tribune*.)

History of Urology

In Illinois

BY JOSEPH H. KIEFER, M.D./CHICAGO

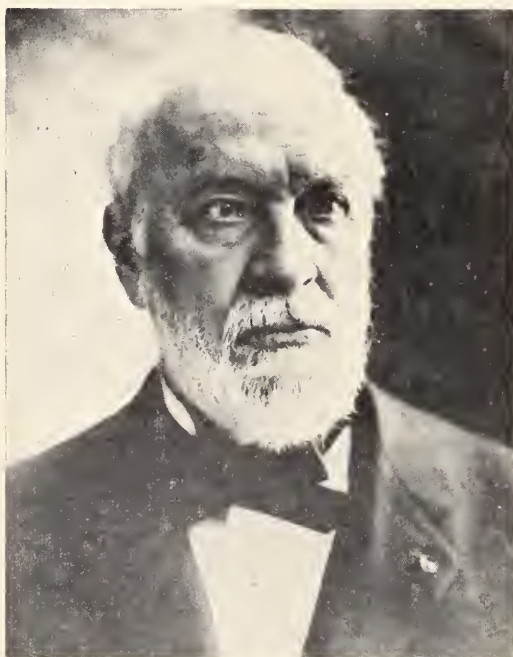


Fig. 1 Dr. Edmund Andrews (1824-1904). Pioneer Urological Surgeon, although on a part-time basis.

The specialty of Urology as we know it today did not develop in Illinois until the end of the 19th century. Before that time its story is intermingled with the general history of medicine and surgery in the state.

The aboriginal Indians did not carry out any urologic procedures, but treated all disease with herb medicines, manipulation and magical rituals. The earliest French missionaries and explorers were usually accompanied by military surgeons, who, we presume, could carry out the procedures of catheterization and trocar puncture of the bladder for urinary retention, since these procedures were part of European army practice. Complicated urologic operations, such as lithotomy or urethrotomy were not carried out on the early frontier.

The first bit of urologic history was the attempt about 1790, by Madame Beaulieu, a midwife of Cahokia, to reduce the incidence of venereal disease by promoting high moral principles. The record does not say how successful she was.

The next item of urologic interest is a listing of the diseases occurring at Fort Dearborn between the years 1829 and 1836. Among 933 cases, seven of venereal disease are listed.

The first French settlements in Illinois were made along the Mississippi River between the mouths of the Illinois, Missouri, and Ohio Rivers. Although the first settlement, Cahokia, was founded on the east bank; St. Louis, established in 1763, on the west bank in the state of Missouri, became the center of activity of the area. A hospital was established there in 1828.

and a medical college in 1840.

The northern section of Illinois was controlled by the British and their Indian allies until after the War of 1812, and the settlement of this section did not begin until the war's end. Fort Dearborn was established in 1803, but the city of Chicago did not begin its phenomenal development until about 1830.

Organized medicine had its start in 1840 when the Illinois State Medical Society was formed and medical journals began to appear. Franklin Medical College was founded in 1842 in Aurora, but closed eight years later. A medical school established in 1843 at Illinois College at Jacksonville lasted only five years.

Rush Medical College in Chicago was chartered in 1836, but classes did not start until 1843. In 1859 several of the Rush faculty resigned to start a new medical school with a graded curriculum. Affiliated at first with Lind University, it eventually became the Medical School of Northwestern University.

Scanning the medical journals from 1840 on, reveals that urologic procedures such as urethrotomy, hydrocelectomy and occasionally lithotomy, were performed and reported. A few men had a special interest in urologic procedures, but none of them restricted his practice to urology.

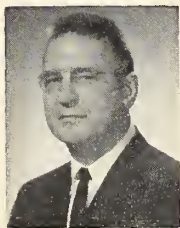
Most prominent by far of these part-time urologists was Edmund Andrews (1824-1904), of Chicago. He made several attempts to improve the endoscope of Desormeaux, which was the forerunner of the modern cystoscope. In 1868 he described a mechanism to feed magnesium wire into the flame of the illuminating lamp to make it brighter; and in 1871, tried a row of gas jets 10 inches long; but neither method was successful. In 1878 he described a hollow sound connected by a

rubber tube to an ear piece so that tiny stone fragments could be identified by auscultation. In 1889 he reported 100 operations for urinary calculus, including 46 cases of litholapaxy and 54 cases of open lithotomy. Dr. Andrews could well qualify as Chicago's first urologist, though on a part-time basis.

Several other doctors had a limited interest in urology. Charles Gilman Smith (1828-1894) was first Head of the Cook County Hospital Department of Skin and Venereal Diseases, but he did not report major urologic surgery. Charles W. Purdy (1846-1901) published a book *PRACTICAL URINALYSIS AND URINARY DIAGNOSIS*, which was very popular, and went through many editions but he did not operate. During this period, many practitioners combined treatment of lower tract infections with dermatology, a combination which extended into the beginning of the modern era. Many of these men, while known as urologists, did not do major urologic surgery.

A few surgeons of this period are remembered because of some particular interest or procedure which they reported. The following are best known:

Daniel Brainard (1812-1866) founder of Rush, reported on the treatment of urethral stricture by dilatation and incision. Isaac N. Danford (1836-1911) is said to have performed the first nephrectomy in Chicago and devised a kidney holding forceps. Christian Fenger (1840-1902) advocated surgical exploration of the opposite kidney before nephrectomy. He also applied longitudinal incision with transverse closure in strictures of the ureteropelvic junction. Nicholas Senn (1844-1908) in 1897 published a monograph on *Tuberculosis of the Genito-Urinary Organs*, and later another on fixation of movable kidney. Malcom Harris (1862-1936) in the precystoscopic period, devised a mechanical urine segregator to be inserted into the bladder to determine the functional capacity of the individual kidneys. Alexander H. Ferguson (1850-1911) reported on the surgery of prostatic enlargement and vesico-vaginal fistula. John B. Murphy (1859-1916) reported on prostatic as well as other urologic surgery. Arthur Dean Bevan (1861-1943) was one of the first to use Roentgen rays to detect urinary stones, and he described the surgical correction of



Joseph H. Kiefer, M.D., is professor of urology and acting head, division of urology, department of surgery, University of Illinois, College of Medicine. A graduate of Northwestern University Medical School, Dr. Kiefer is a member and former officer of the Society of Medical

History of Chicago and a member of the American Association for the History of Medicine.

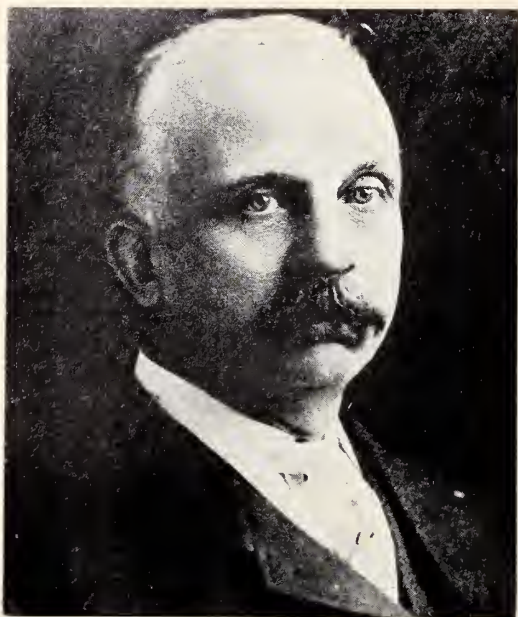


Fig. 2 Dr. William T. Belfield (1856-1929). The "Father of Urology in Illinois" and first President of the Chicago Urological Society.

varicocele and undescended testis.

An important man of the transition period was G. Frank Lydston (1858-1923) who in 1883 was named "Lecturer on Genito-Urinary Surgery" at the College of Physicians and Surgeons. This is the earliest recognition of this specialty as a separate entity.

The man honored as the 'Father of Urology' in Chicago and Illinois was William T. Belfield (1856-1929). Born in St. Louis and a graduate of Rush, his first work was in bacteriology, in which he acquired a national reputation before becoming active in clinical urology. He was invited to deliver the Cartwright Lectures in New York in 1883, giving the first discussion in the United States of bacteriology in relation to disease. He was the first in the U.S. to demonstrate the tubercle bacillus and the gonococcus. He published a book, *DISEASES OF THE URINARY AND MALE SEXUAL ORGANS* in 1884. He did the first suprapubic prostatectomy, publishing a preliminary report in 1887. He is said to have brought the first cystoscope to the Middle West that same year. In 1890 he reviewed all the cases of prostatic surgery up to that date and was the author of a monograph on diseases of the prostate in 1893. He introduced the procedure of injecting medicines into the vas deferens in the upper scrotum, still known as the Bel-

field Operation.

Another early urologist was Gustave Kolischer (1863-1942) a pioneer in ureteral catheterization and in the destruction of bladder tumors by electric current. Louis Ernest Schmidt (1869-1957), born in Chicago and a graduate of Northwestern was a full-time urologist from the start of his practice, and through his efforts in 1900, a separate Division of Urology was established at Northwestern. Daniel Eisendrath (1867-1939) started as a general surgeon, but early restricted his work to urology. With Harry C. Rolnick he published a textbook of urology, which, after many editions, is still in print.

At the turn of the century urology separated progressively from the general practice of surgery. The most important factor was the invention of the cystoscope. Designed by Max Nitze of Berlin between 1876 and 1890, it was much improved and made more practical by the use of the newly invented Edison electric light bulb. The early instruments required considerable training to be adept in their use, and those who were capable soon became a special group. The development of ureteral catheterization and the use of X-rays during the middle 1890's enabled the cystoscopist to obtain separate urine from the kidneys and outline the kidneys and ureters by injection of radio-opaque solutions. All this permitted great exactness and accuracy of diagnosis and made urologic surgery more safe and effective.

Surgeons with a major interest in urology began to band together, and in 1887, the first group, the American Association of Genito-Urinary Surgeons was founded and the American Urological Society in 1902. Within the next year the Chicago Urological Society was formed and became the first branch of the national organization. William T. Belfield was its first President, and Louis Schmidt, Vice-President.

The founding of the Chicago Urological Society served to define and mark off the field of urology as a distinct surgical specialty. While a few men continued to combine urology with general surgery, this practice died off with its practitioners. From this time on, any person who held himself to be a urologist had to confine his work to this field, and the medical schools

accepted only full-time urologists on their teaching faculties.

Of the founding group of the Chicago Urological Society several later became very eminent. Dr. Belfield, the first President, was a professor at Rush and became President of the A.U.A. in 1909. Gustave Kolischer also continued as an active teacher and clinician until his death in 1942. Louis Schmidt exerted a tremendous influence during his career of almost 50 years as Head of the Urology Division at Northwestern and as President of the Chicago Urological Society, the A.U.A. and the American Association of Genito-Urinary Surgeons.

Robert Herbst (1877-1951), an associate of Dr. Belfield, devised a method of catheterizing the ejaculatory ducts. With him for many years was Hugh J. Polkey. Both taught at Rush. Bud Clark Corbus (1876-1954) was one of the first to bring the new drug salvarsan from Europe and he helped develop the Corbus-Ferry gonococcus vaccine.

Until World War I, the training of urologists in Illinois was confined to Chicago. There were no residencies and anyone wishing training would enter a preceptorship or association with a practicing urologist for an indefinite period.

The first training center was the Cook County Hospital. Until 1915 it had no special urologic facilities. In that year, Frank Phifer (born 1886), an associate of G. Frank Lydston, was appointed the first cystoscopist, and soon acquired a helper, Harry Culver (1885-1959). The surgical urologic procedures were still done by the general surgeons. This arrangement was interrupted by World War I. Doctors Phifer and Culver both served in the armed forces as urologists and on their return once more set up the cystoscopic room at Cook County. In 1921 a urologic surgical service was begun and the first resident urologist was appointed. During the next decade other large hospitals began to appoint urology residents, and this trend was accelerated after the founding of the American Board of Urology in 1934.

Our involvement in World War I caused a great disruption of medical practice, but was a great impetus to urologic practice in the "downstate" areas, that is, outside the Chicago region. Here urology was

rarely practiced as a distinct specialty before the war. Major cases in the southern portion of the state gravitated to St. Louis or Indianapolis, and in the northern portion of the state to Chicago.

Men who practiced medical urology or who were inclined to it were often assigned to urologic wards in the armed services. While military practice consisted chiefly of lower tract infections, other urologic conditions were also included, and diagnostic facilities were available, so that these men were able to improve their use of the cystoscope and their surgical technique. On their return to civilian life, many began to specialize at least part time in urology. The recognition of urology as a distinct specialty in the military service now carried over into civilian life.

In the southern portion of Illinois, Royal Thiarpe began urologic practice in 1919, in East St. Louis. He died in 1933, and was succeeded by Justin J. Cordonnier who continued until 1941, when he moved across the river, to St. Louis. One other urologist, Walter Wilhelm, did cystoscopic and transurethral surgery in this area but no open surgery.

In Decatur, I. H. Neece returned from World War I and in 1920 associated with Robert L. Morris in the practice of urology. When Dr. Morris died in the late 1940's Arthur C. Simon became associated with Dr. Neece. In the Springfield area, the first urologist was Herbert B. Henkle, Sr., who began practice sometime in the early 1920's.

In the Peoria area, it has been said that a W. W. Cutter was the first man to do a cystoscopic examination. A leading early urologist was Arthur Sprenger. Another pioneer was Bransford Adelsburger who died in the 1930's and was succeeded by Frank Christiansen.

In 1925 C. Grafton Weller (b.1895) began practice in Aurora. He continued on the Rush faculty in Chicago and maintained membership in the Chicago Urological Society. At Rockford, the earliest urologists were Edward H. Weld and Henry B. Searle, who began in the 1920's.

In the region of Waukegan, the first urologist was Alexander Schlapek. Near Waukegan, Robert Herbst, mentioned above as practicing in Chicago, also did urology at the nearby Lake Forest Hospital.

In Danville, the earliest urologist was J. K. Funkhouser who did lower tract urology from 1925 until his death in 1934. Shortly thereafter, Harlan English began full scale urologic practice. A past president of ISMS, he had a great interest in organizational medicine and is still active.

In Olney lived one of the few men who did open major urologic surgery in "downstate Illinois" before World War I. His name was Frank Webber. After a trip to Baltimore about 1900 to observe Hugh Young doing perineal prostatectomy, he returned to Olney and did many with success on patients from a wide area of eastern and southern Illinois and western Indiana, until about 1935.

After World War II younger men who had completed their urologic training either just before, or during the war, moved into many downstate cities and began the full-time practice of urology.

William T. Belfield, the Dean of Chicago Urology, died in 1929. In 1927 the Chicago Urological Society, during the presidency of Dr. Russell D. Herrold had established the William T. Belfield Lecture as an annual memorial event to begin the Society's active season.

The story of urology in Chicago from the 1920's on is probably best told in relation to the various teaching institutions and clinical centers. Nearly all the eminent urologists were associated with these teaching centers and we will review them in this light.

Rush Medical College did not appoint Dr. Belfield as Professor of Genito-Urinary Surgery until 1909, and he became Emeritus in 1924. His associate, Robert Herbst, was on the Rush teaching staff from 1904 until 1945. Another teacher at Rush was Herman Louis Kretschmer (1879-1951) who began work with Dr. Schmidt. He published widely and was elected President of the A.M.A. as well as the various urological societies. He was one of the most vociferous advocates of transurethral surgery when it became practical in the early 1930's. He wrote a "History of Urology in Chicago" for the A.U.A. History of 1933.

Among other Rush teachers were Norris Heckel, an associate of Dr. Kretschmer's who also became widely known. Active from 1923 on, was Charles Grafton Weller. He has been for many years His-

torian of the North Central Section of the A.U.A. Knowlton Barber, also associated with Rush from 1926 on, transferred to Northwestern in 1939. He wrote a "History of Urology in Chicago" published in Chicago Medicine in 1961. Others on the Rush staff prior to World War II were James Merricks, associated with Dr. Herbst, George Baumrucker who invented several transurethral instruments, and Thomas Cottrell.

The School of Medicine of Northwestern University, founded in 1859, had its urology department inaugurated by Louis Schmidt in 1900, as mentioned above. With him early was Victor D. Lespinasse (1878-1946). He was interested in blood vessel suture and organ transplantation and in 1913 reported transplantation of a testicle from one human to another. Another was Harry Culver, who with Frank Phifer in 1915, had helped inaugurate the Cystoscopic Department of Cook County Hospital. In 1920 he became associated with the University of Illinois faculty, but joined the Northwestern Staff in 1927. Associated with him in much of his career was William J. Baker (1894-1958), one of the early Cook County residents who was likewise very interested in urology society affairs and became President of the A.U.A.

Eminent among the men trained by Dr. Schmidt was Dr. Irving J. Shapiro (b. 1898) of Michael Reese Hospital whose pyelogram clinics have been for many years a popular annual feature of the Chicago Urological Society meetings.

When Dr. Schmidt retired in 1947 as Chairman, he was succeeded by Vincent J. O'Connor (1893-1963), who had begun teaching at the University of Illinois, joining the Northwestern staff in 1942. Associated with him were J. Kenneth Sokol and George J. Bulkley. Other well-known urologists on the Northwestern teaching staff included Harry C. Rolnick, mentioned previously as co-author with Daniel Eisendrath of a popular textbook of urology. Also, Joseph Eisenstaedt, Irvin S. Koll, L. L. Veseen, James Farrell, T. P. Grauer, Andrew McNally, Fredrick Lloyd, Clay O. Miller, James S. Reynolds, and Leander Riba.

The University of Illinois College of Medicine was organized in 1882 as the College of Physicians and Surgeons. At its

very beginning a Professor of Genito-Urinary Diseases was named, Theodore A. Keeton, and a Lecturer, G. Frank Lydston. While Dr. Keeton's name disappeared the following year, Dr. Lydston became Professor in 1891 and continued until 1913. He was much interested in testis transplantation and did many animal experiments.

In 1913 Daniel M. Eisendrath, at first listed as Professor of Surgery, became Professor of Surgery of the G-U System. The same year, Charles Morgan McKenna (1880-1945) appears among the faculty. He became Chairman in 1920 and remained so until his death in 1945. He was a colorful and energetic teacher and surgeon, on the attending staffs of Cook County and St. Joseph Hospitals as well as the Research and Educational Hospitals of the University of Illinois.

In 1923 Vincent J. O'Connor joined the teaching staff and remained until 1942 when he transferred to Northwestern to become Head of the Urology Department there in 1947. A very personable and able man, he had a nationwide acquaintance and reputation and was President of most of the urology societies and recipient of many honors and awards.

Russell Dorr Herrold (1888-1960) began teaching at Illinois in 1923, and continued on the faculty until his death in 1960. An active investigator and an acknowledged expert in bacteriology of the urinary tract; he was a national authority on the properties of antibacterial drugs and antibiotics.

Among others at the University of Illinois before World War II were E. Earl Ewert, who left in 1937 to join the Lahey Clinic staff. Others were Frederick W. Schacht, Dorrin, Rudnick, John T. Gernon, C. Otis Ritch, Joseph S. Drabanski, and Joseph H. Kiefer, who succeeded Dr. McKenna as Head of the Division of Urology upon the latter's death in 1945.

The Stritch School of Medicine of Loyola University began in 1911, by the amalgamation of several schools. Filip K. Kreissl was Professor until 1918 when the school absorbed the Chicago College of

Medicine and Surgery, and John S. Nagel became Professor. In 1920 Frank Phifer became Professor and remained until he became emeritus in 1937. He was the chief exponent in the Chicago area of the perineal approach for prostatic surgery. He was succeeded by Herbert E. Landes who continued until his death in 1964. Also on the Loyola faculty we see the names of Thomas F. Finnegan in 1920, and Harry Dooley in 1922. Also at that time appeared the names of Alfred E. Jones, Edward W. Hirsch, and John Ferrin, in 1928 Joseph E. Laibe and Edward W. White, and in 1930 Clarence Saelhof. Harry Rolnick, mentioned previously, was also on the Loyola faculty from 1930 to 1937 when he transferred to Northwestern University.

The Medical School of the University of Chicago began in 1901 as an affiliation with Rush by which the two basic science years were taught at the University of Chicago. In 1927 with the opening of Billings Hospital, instruction in the last two clinical years was begun at the University of Chicago as well. In that year, Charles Huggins was appointed as Instructor in Urology, and was soon named Professor and Head of Urology, continuing until 1951 when he retired to devote fulltime to research work. Dr. Huggins has been a tireless investigator in the laboratory and is best known for his research on the endocrine treatment of prostatic carcinoma by orchidectomy and adrenalectomy for which he was to receive a Nobel Prize.

This short sketch of the History of Urology in Illinois, due to limitations in space must be closed at this point. As all history, it is a continuing story, and details of the period from World War II onward will have to await a later opportunity. ◀

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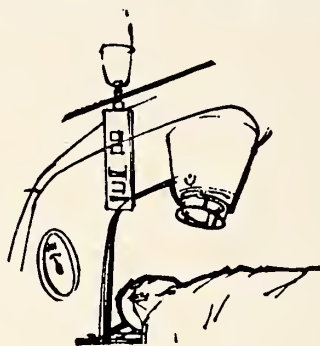
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Oral Treatment of Iron Deficiency Anemia

By OLIVER W. CRAWFORD, M.D./CHICAGO

According to recent studies, some iron deficiency anemia occurs in over one-half of supposedly normal infants in the United States, with a greater frequency of deficiency in lower socioeconomic groups.¹ In our private practice, including predominantly Negro patients of medium-low to low socio-economic background, we often encounter iron-deficiency anemia accompanying or complicating other conditions, particularly those of an infectious or allergic nature. We also see a similar frequency among these patients in a hospital clinic setting. As a general rule, indications for parenteral administration of iron in children are rarely present. The commonly available ferrous salts are relatively well tolerated by most children and usually give a very satisfactory response in a hospital environment where regular intake of medication as prescribed is assured. In private practice, we find that oral treatment with ferrous salts often gives less satisfactory results, in part because of marginal palatability and the need for several daily doses. This report describes the use of a new low-molecular weight iron-carbohydrate complex, available in a palatable oral elixir preparation for once-daily dosage.

Medical Progress



HARVEY KRAVITZ, M.D.
Medical Progress Editor

Material and Methods

This study extended over a period of eight months and was carried out in pediatric outpatients visiting our private clinic either for follow-up or any other conditions not requiring hospitalization. A large part of these children suffered from recurrent upper respiratory infections; many of the rest had various allergic diseases, including recurrent eczema, pollinosis, carbohydrate intolerance, and asthmatic bronchitis. In all infants and children who showed any clinical evidence of potential iron deficiency, the hemoglobin concentration was determined using the Coleman Jr. hemoglobinometer according to the Drapkin's method; the hematocrit was measured in Wintrobe tubes according to standard technique. Sickling was searched for in the blood from all patients after incubation with sodium metabisulfite. The possible presence of thalassemia was excluded on the basis of family history and clinical criteria. The percentage of reticulocytes was also determined in all patients in the study. All laboratory studies were carried out in our own clinic laboratory.

All 53 patients seen during the period and found to have a hemoglobin concentration below 10 gm. per 100 ml. blood were selected for oral treatment. The hemoglobin ranged between 5.6 and 10; hematocrit between 21 and 33; and reticulocytes between 0.5% and 1.6%. The ages ranged between 4 months and 13 years, but the majority were infants, only 5 of the 53 being above 6 years of age. The mothers

were queried as to the presence of any drug or other allergies which might limit treatment. They were informed that their children had a degree of iron deficiency anemia requiring oral treatment and given a sufficient amount of the preparation for three weeks' treatment together with appropriate instructions in its use. Mothers were warned to discontinue the preparation and phone the doctor immediately should any adverse effects occur.

We chose for treatment a new preparation containing ferric iron complexed to a polysaccharide. In contrast with other known preparations of this type, the polysaccharide used is of very low molecular weight. The new complex contains 25% of bivalent iron and has been found to possess an extremely low degree of toxicity while its absorption through the digestive tract approximates that of ferrous salts: the LD₅₀ of the new iron complex in mice was found to be in excess of 3200 mg. Fe/Kg (the highest dose practical to administer in mice by gavage; all 8 animals so treated survived) as compared to LD₅₀s of 245, 540, and 630 for ferrous sulfate, fumarate, and gluconate respectively; while chronic toxicity studies in rats and dogs produced no essential pathologic changes in contrast to considerable renal damage seen with comparable doses of ferrous sulfate.² Similar results were obtained in another comprehensive pharmacologic investigation in several species; the rise in serum iron following oral administration of the new iron complex was more gradual and prolonged than with ferrous salts.³ The clinical safety and effectiveness of the preparation has recently been confirmed in a small group of geriatric patients⁴ as well as in a preliminary study in 16 pediatric patients.⁵

The manufacturer-recommended dosage of this preparation for infants below age two is one drop per pound body weight

tid or qid (equivalent to 2.4 mg. elemental iron per lb. daily). In order to simplify matters for the mothers we rounded their dose to ½ teaspoonful (approximately 90 drops or 25 mg. iron) once daily for infants. Eight of the older children received 1 teaspoonful (100 mg. iron) once daily and the three children aged 12 or 13 received two teaspoonfuls.

The elixir in question seems particularly suitable for pediatric use because of its pleasant taste and easy miscibility with milk, infant formulae, or juices. Although the iron is firmly bound and wholly non-ionized, it apparently dissociates without difficulty in the acid environment of the stomach and is so available for duodenal and distal absorption.

The Second Visit

At the second visit, three weeks after the first, all patients were again interrogated regarding side effects, and blood specimens were again obtained for repetition of all laboratory tests. The mothers were again provided with a sufficient amount of medication for three weeks' treatment, and told to return at that time.

Of the 51 patients, four did not complete the study. Two moved with their families after the 3-week examination showed normal hemopoietic response.

The other patients received only a few doses of the preparation: one was found to have sickle-cell anemia; the other, a five-month girl with recurrent upper respiratory infections, vomited each time after the preparation was given so that attempt at further treatment with it was discontinued in her case after three days.

The table shows the progressive increase in hemoglobin and hematocrit values, with the patients arbitrarily broken down into four groups according to the initial hemoglobin values. Two of the patients, one each in Group III and IV, moved away during the second part of the study so that the 6-week results include data on only 49 patients. As can be noted, the group of patients with the most severe degree of iron-deficiency anemia (initial hemoglobin at 7.6 or lower average 6.6), showed the best utilization of iron during treatment with the new iron-carbohydrate complex. Hemoglobin and hematocrit in the other three groups improved consistently over the six-week period of treatment, but to a les-

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TABLE—HEMOGLOBIN AND HEMATOCRIT RESPONSE TO ORAL LOW-M.W. IRON-POLYSACCHARIDE COMPLEX IN CHILDREN WITH IRON-DEFICIENCY ANEMIA

Average Hemoglobin and Average Hematocrit Response to Treatment					
Group	Initial Hb Range	No. of Patients	Initial Hb (Hct)	3-Week Hb (Hct)	6-Week Hb (Hct)
I	5.6- 7.6	11	6.60 (22.55)	8.34 (26.77)	9.51 (31.10)
II	7.7- 8.5	9	8.22 (25.88)	9.03 (28.77)	9.51 (31.44)
III	8.6- 9.3	14	9.02 (28.30)	9.58 (30.64)	10.37 (34.08)
IV	9.4-10.0	17	9.64 (30.94)	10.47 (33.87)	10.93 (36.19)
ALL	5.6-10.0	51	8.37 (26.92)	9.36 (30.01)	10.08 (33.29)

ser degree. There was very little difference in utilization of iron between these three groups, and the 17 patients with very mild anemia (average initial hemoglobin 9.64) showed nearly as much improvement in this respect as the other two groups.

The best response was seen in a 13-year-old girl with an initial hemoglobin of 6.2 gm. per 100 ml, hematocrit 22 and 0.7% reticulocytes: after six weeks of treatment with two teaspoonfuls (=200 mg. elemental iron) daily, her hemoglobin was 12.4 with hematocrit at 42 and 1.2% reticulocytes. A very satisfactory and rapid recovery from anemia was also seen in a 3-month old boy who had had two transfusions due to maternal Rh-incompatibility; his hemoglobin went from 5.6 to 10.2 following six weeks of treatment with 50 mg. iron daily in the form of the iron-polysaccharide complex. As could be anticipated, utilization of iron was generally best among children with a more severe degree of anemia.

Of the 49 patients who continued treatment for six weeks, all but two showed further improvement in laboratory values. The two exceptions were a boy 13, whose initial Hb. of 9.6 had risen to 10.2 after three weeks, and fell to 8.0 at six weeks; and a 1-year-old girl whose initial Hb. of 8.2 was 8.4 at three weeks, but 7.2 at six weeks. Irregular dosing was considered one possible reason for the lack of response in these 2 cases.

In comparison with the frequency of gastrointestinal complaints using the ferrous salts, side effects were virtually absent, with the exception of one infant who, as noted above, apparently could not tolerate the elixir and vomited after each of 3 attempted doses. The only other signs of potential side effect were noted in two children aged 4 and 6 respectively; these consisted of vague complaints of mild gastric pain after several of the doses. There was no other report of nausea, emesis, con-

stipation, diarrhea or any other sign of adverse effect which could be attributed to the medication in any of the other 49 children treated.

Comment

The rapid growth during infancy and childhood requires optimal provision of dietary iron with normal absorption and utilization of it to satisfy body requirements. Even assuming a diet containing an adequate concentration of this mineral, the actual availability of iron can be decreased by many factors. The earlier assumptions about the physiological unavailability of non-ionized iron and the rapid absorption of ionized iron are no longer held valid; the type and pH of gastrointestinal secretions; the presence of reducing agents, phytic acid, calcium, and phosphorus; pyridoxine deficiency; presence of inflammation; sub-clinical allergy to some foods are among the many factors that may exert decisive effects on the absorbability of iron through the digestive tract.⁷⁻⁸ The relationship between iron deficiency anemia and respiratory infections has been established beyond doubt;⁹ and enteric irritation from cow's milk may contribute significantly to occult blood loss and resulting hypochromic anemia in susceptible infants.¹⁰ It is easy to visualize how the listlessness and anorexia of anemic children can easily lead to a vicious cycle of poor diet, chronic anemia, and recurrent infections; and how these factors are particularly burdensome among lower socio-economic strata where ignorance and poverty represent another obstacle to early diagnosis and appropriate treatment.

There have been several attempts to formulate a carbohydrate complex with iron in order to produce a palatable form of iron free of the gastrointestinal side effects commonly accompanying treatment with ionized iron preparations. While tolerance

was generally satisfactory with these carbohydrate complexes, the main disadvantage of these preparations was an unpredictable, often inadequate, degree of absorption. The new low-molecular-weight iron carbohydrate complex seems to permit adequate utilization of iron and a satisfactory hemopoietic response upon oral administration. The gratifying response generally obtained in children with only a single daily dose makes this type of preparation a convenient and relatively reliable method to treat iron deficiency anemia in private practice. Although toxicity and tendency to produce gastrointestinal side-effects seem much lower with this preparation than with the usual ferrous salts, iron intoxication is a definite possibility, and parents should be especially warned to keep the preparation out of the reach of children in view of its relative palatability.

Summary

Iron deficiency anemia is frequent in Negro children of low to medium-low socio-economic level, living in a metropolitan area and treated in private for infectious or allergic disorders. A new liquid oral preparation containing ferric iron complexed to a low-molecular-weight carbohydrate, requiring only one dose daily, was used in the treatment of 52 such children with initial hemoglobin levels of 10 gm. per 100 ml. or lower. An adequate hematologic response as judged by hemoglobin, hematocrit and reticulocytes was seen in 47 of the 52 within three to six

weeks of treatment. One child could not tolerate the preparation; two others complained of occasional mild gastric distress which did not prevent continued treatment. ◀

Generic and Trade Names of Drugs

Oral iron—l.m.w. polysaccharide complex—Niferex

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In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

WILLIAMSON COUNTY: Herrin; population: 10,000. Trade area: 50,000. Physicians ages: 59, 63, 46, 53, 31, 51, 55. Local hospital. Forty miles from Paducah, Ky.; population: 50,000. Four drug stores. Several choice office suites; 1 in building with 2 G.P.s. Hospital planning to build a physician's office building connected with hospital. Financial assistance available. Predominant nationality: Italian. Protestant and Catholic churches. Grade and high schools. Several large state parks within 30 miles. Hunting, fishing, golf, etc. immediately available. For further information contact: Larry Feil, Administrator, Herrin Hospital. Phone: 942-2171.

WINNEBAGO COUNTY: Pecatonica; population: 1,200. Two physicians, 1 wishes to retire after practicing here for 40 years. His building for rent if desired. Nearest hospitals at Rockford and Freeport, 14 miles. One prescription drug store. Eight room office completely remodeled at the cost of \$20,000, for sale or rent. Equipment available if desired. German and Swedish predominant nationalities. Agricultural and industrial area. Catholic and Protestant churches. Grade and high schools. Many recreational facilities available in nearby Rockford. For further information contact: B. C. Schnell, Jr., M.D., 303 N. Main, Rockford; Phone: WO 2-4911.

WOODFORD COUNTY: Metamora;

population: 2,200. One physician; urgent need for a second. Nearest hospitals at Eureka, 10 miles, and 3 in Peoria, 15 miles. Population of Peoria, 135,000. Financial assistance available. Predominant nationalities: German and Irish. Agricultural and industrial area. Protestant and Catholic churches. Grade and high schools. Two colleges within 15 miles. Community swimming pool. Three golf courses within 10 miles. Unusual financial opportunity. For further information contact: G. J. Scheirer, M.D., 126 N. Davenport St., Metamora; Phone: 367-4891.

Subsequent to the listings over the past 24 months, the following list of openings for associates in general practice is furnished. These pertain to Cook County. It will be continued next month.

COOK COUNTY: Chicago; Chicago Board of Health. Excellent opportunity at Tice Clinic, Cook County Hospital, 1835 W. Harrison, Chicago. Full or part time. Nine to 5 or 9 to 12 or 9 to 1. G.P., Pediatrician or Internist. Salary open—excellent. Illinois license required. For further information contact: S. R. Rosenthal, M.D. Phone: 633-6293.

COOK COUNTY: Lemont; population: 4,000. Opening for physician in Brown Medical Clinic, 50 New Avenue, Lemont. Twenty-eight miles from Chicago. Fifteen minutes from Oakbrook shopping center. One year contract for \$24,000. Modern office, examining rooms, fully equipped lab, X-Ray, etc. Fifteen minutes from a 250 bed hospital. Partnership after 3 years. For further information contact: Bruce Brown, M.D., Brown Medical Clinic, 50 New Avenue, Lemont. Phone: CL 7-2265.

COOK COUNTY: Chicago. J. R. Bernier, M.D., in need of an associate. Newly created position due to heavy work load. Position available immediately. Age group 30-50 preferred. Salary \$1,000+. Well equipped 6 room office. Privileges in nearby hospitals available. For further information contact: J. R. Bernier, M.D., 1020 W. Argyle, Chicago, 60640. Phones: LO 1-8885 and LO 1-8162.



The expanding role of government in the nation's health concerns has been accompanied by the growing involvement of the medical profession in matters of legislation. Indeed the legislative arena has become the focal point for many of today's most controversial social-medical issues such as abortion, alcoholism and mental health.

The 1969 IMJ Survey on Major Issues asked for your opinion on these and other important concerns that hold legislative implications. In this, the last of three survey analyses, we examine the views of the 3,500 physicians who responded to the survey.

In presenting this final article, I would like to thank all of you who took time out from your busy practices to let us know your viewpoint. We especially appreciate the written comments that many of you included with your survey questionnaire. It is now the task of ISMS and its officers to translate your desires into constructive action. Thanks to your support, we look forward to this task with renewed confidence and enthusiasm.

*Matthew B. Eisele, M.D., Chairman
Council on Public Relations and
Membership Services*



Solving the Abortion Dilemma

After two years of debate, the ISMS House of Delegates in May, 1969, passed a resolution urging the Illinois General Assembly to broaden state law to permit induced abortion under a number of circumstances. But the House of Delegates' action came too late to have impact on legislative deliberations and five bills for liberalizing the state abortion law were defeated. Thus far, Colorado, Georgia, Maryland, North Carolina, and California have broadened their laws to allow induced abortion if there is documented evidence that continuation of pregnancy threatens the physical or mental health of the mother, or that the child would be born with an incapacitating physical or mental abnormality.

In last year's IMJ Survey on Major Issues, Illinois physicians were asked for their stand on the abortion question, and more than 76 per cent of the 3,000 respondents favored changes in the current law. In this year's survey, you were asked how ISMS should actively pursue revision of the law:

Stimulated by last year's ISMS opinion survey, your House of Delegates approved liberalizing Illinois' therapeutic abortion laws. Should ISMS initiate an educational campaign to achieve this goal?

Yes	77%
No	23%

A breakdown of the survey responses to this question indicates the strongest support for an educational program comes from Chicago area physicians and from specialists rather than GPs. But the most outstanding difference of opinion seems to exist between older doctors and younger ones. Whereas 81 per cent of the physicians over 55 years old back an educational campaign, only 69 per cent of the physicians under 40 years old favor the proposal. This confirms the results of last year's survey which showed that older physicians are the strongest proponents of liberalized abortion laws.

Since the majority of respondents, regardless of age, favor an educational program on the abortion question, ISMS will draw up plans for such a project. The goal of the program will be to bring the problem before the public and to encourage action at the next regular session of the General Assembly in January, 1971.

Curbs On Chiropractic

Although physicians outnumber chiropractors in Illinois by about 14 to 1, chiropractic influence in the state legislature is considerable. During the last session of the General Assembly, bills were introduced to allow chiropractors to conduct school physicals and to allow chiropractic membership on the clinical laboratory and Blood Bank Advisory Board. Both measures failed, but a third one that prevents insurance companies from excluding chiropractic services as a benefit in health insurance policies passed, and has been signed into law.

Meanwhile, evidence disputing chiropractic theory and treatment continues to grow. An in-depth report released last year by the Department of Health, Education and Welfare showed that chiropractors are not properly trained to diagnose or treat disease. Therefore, the report concluded that chiropractic services should not be reimbursable under Medicare.

Contrary to the popular notion that chiropractors treat just "back trouble," a survey conducted by the American Chiropractic Association revealed that more than half of the nation's chiropractors treat complicated medical conditions through "subluxation" of the vertebrae. Among these conditions are chronic heart disease, high blood pressure, headaches, asthma, ulcers, colitis, hemorrhoids, dermatitis, and mental and emotional problems.

In view of the growing influence of chiropractic, the survey asked what steps ISMS should undertake:

Chiropractors are seeking authority to give school physicals, serve on medical advisory boards, collect from governmental and private health insurance programs. Should ISMS intensify its legislative and educational efforts against such moves?

Yes 89%
No 11%

Although the vast majority of the respondents favor the proposal, strongest backing comes from younger doctors, under 40 years old. Chicago area physicians endorsed the proposal more strenuously than downstate doctors.

Mandate On Mental Health



Ten years ago, Illinois took a major step toward improving mental health services for its residents through a massive reorganization of the state's mental health program. The reorganization was designed to provide mental health services on a community level, rather than in distant state hospitals. An outgrowth of this community-centered mental health movement has been the passage of state legislation allowing communities to develop local psychiatric services. Thus far 31 counties, municipalities or other governmental units have taken advantage of this legislation, which permits a tax levy up to one mil. Such taxation must be approved by voter referendum.

According to mental health authorities, the support of the medical profession has been crucial to the success of many of these referendums. In fact, a number of referendums have failed in areas where the local medical community took no stand on the issue. The survey asked how county medical societies should be involved in local mental health referendums:

Since physicians often refer patients to either private or public resources for mental health treatment, the survey asked if you were in agreement with the Department's current admissions policy:

In most cases, the Department of Mental Health limits hospital admissions to only "high risk" individuals whose need for hospitalization is imminent or mandatory, while individuals with less severe disturbances are referred elsewhere. Should ISMS support the Department in this policy?	Yes 62%
	No 38%

The Department is aware that deviation from admission policy is often necessary, especially when alternative resources for care are not available. However, the survey response seems to indicate that physicians believe the Department's policy is a worthy goal.

State law permits communities or counties to establish local mental health services through imposition of a tax levy, approved by local referendum. Should county medical societies:

a. Support such referendums in areas without adequate mental health services?	Yes 77%
	No 23%
b. Initiate such referendums?	Yes 59%
	No 41%

A breakdown of the responses indicates that younger physicians feel county medical societies should be more active in initiating referendums, while older doctors believe county societies should limit their

involvement to supporting such referendums. However, heavy endorsement from all aspects of the medical profession indicates that Illinois doctors want their county medical societies involved to some degree in improving local mental health services.

The role of the Illinois Department of Mental Health in the delivery of psychiatric services has changed as communities have been able to develop local resources for treatment. The Department now attempts to limit hospital admissions to persons who are not suitable for community treatment resources. These persons are defined as "high risk", in that they are "acutely in need of hospitalization."

More Aid To Alcoholics

Dr. Roger O. Egeberg, assistant secretary for medical and scientific affairs of the Department of HEW, has estimated that there are between four and six million chronic alcoholics in the U.S. He has commented that: "Our lack of knowledge (about alcoholism) is exceeded by our seriously inadequate efforts to apply what we already know to the detection, prevention, and rehabilitation of the victims of alcoholism."

Last year's ISMS House of Delegates adopted a statement from the Committee on Alcoholism which pinpointed alcoholism as "... a health problem, and therefore, ... within the purview of the medical and other health professions." The survey asked how the problem of the chronic alcoholic should be handled:

Your House of Delegates has emphasized that alcoholism is primarily a health problem. Should ISMS seek legislation providing medical care for arrested chronic alcoholics?	Yes 75%
	No 25%

Unfortunately, a 1968 U.S. Supreme Court decision upheld the right of law authorities to jail chronic alcoholics for public intoxication. Several groups are now working to reverse the decision, and thus spur state and local governments to provide adequate treatment services for alcoholics. The survey results should provide impetus to their efforts.

In the February issue of the *Illinois Medical Journal*, a sequel article to this concluded series of three analyses will compare the answers of ISMS members to each question with responses from medical students, interns, and residents.

"There is nothing wrong in change, if it is in the right direction. To improve is to change. To be perfect is to have changed often."—Winston Churchill.

Confrontation Technique

Applied To Delirium And Confusional States

BY H. H. GARNER, M.D./CHICAGO

The Syndrome

Alerting and orienting factors in the mental processes are intimately related to attention and perception. Patients may show considerable disturbance in the mental functions of being alerted or oriented because of the changed physiologic state of the sensory apparatus. Other causes include changes in organizing and integrating cerebral functions which distort the perception of correctly sensed stimuli. Perceptual, alerting, or attention phenomena, when not in consonance with reality or when vague and elusive or very hyperactive, disrupt the behavioral effectiveness of the individual. Cyclic patterns develop which in turn have feedback effects in creating changes in the perception, alerting, or orienting functions. The altered

physiological functions found in delirium represent but one of the possible perceptual difficulties. Impaired perception may follow upon minimal stimulation of the reticular system, i.e., any impairment in the nature of sensory deprivation (underload). Perceptual efficiency is also impaired with overstimulation referred to as an overload of sensory input. Anticipatory or alerting orienting and supportive attitudes and attention are habitual patterns which can be disrupted by external stress, internal stimuli that occupy the channels of perception or feed discordant messages to the central integrating apparatus or through processes which with varying degrees of intensity intrude upon ongoing involvement with the external world (Lipowski).¹

Any patient approaching or recovering from a state of stupor or coma may be described as being delirious or confused. Any state of cerebral insufficiency due to oxygen lack, glucose or other essential substrates, disturbance in intra-cellular or extra-cellular enzymes, dysfunction of synaptic transmission or cell membrane biochemical systems can be of etiologic significance. Therefore, states of delirium and confusion may be found in patients with severe anemia, fever, peripheral circulatory collapse, cardiac failures of any nature, pulmonary decompensation, hepatic, or renal failure. It has been estimated that 10% of hospitalized patients may suffer from a period of delirium or acute confusional disorder.



H. H. Garner, M.D., is professor and chairman, dept. of psychiatry and neurology, the Chicago Medical School and the Mt. Sinai Hospital Medical Center. He is a researcher in confrontation techniques and methods in psychotherapy, and a pioneer in developing continuing education programs in psychiatry for non-psychiatrically trained physicians. Dr. Garner received his M.D. from the University of Illinois, College of Medicine. He is also consulting at the V.A. Hines Hospital.

The Clinical Picture

The clinical picture may be said to be kaleidoscopic in expression and varies from mild slowing of the EEG to marked slowing of the electroencephalogram and symptoms which can include being quiet and having difficulty in recognizing people and surroundings, withdrawal from contact and expressing feelings of being weak, tired, and sleepy. Another syndrome may consist of the overt evidence of cognitive disorder in the patient's slow responses, the obvious facial expressions of perplexity and memory concentration and the orientation defects as a communication exchange takes place. Anxiety, hyperhidrosis, tremulousness, hyperventilation and tachycardia, in a patient, is easily identified as a possible early delirium tremens. Especially is this so when combined with fitful sleep, nightmares, pronounced startle reactions and gestures suggesting a desire to escape from a threatening experience. Illusions, delusional thinking, and hallucinations in a state somewhat free of the anxiety syndrome just described above may occur or such symptoms add to the intensity of the disrupting upheaval of delirium tremens. The muttering, incoherent patient may represent a very severe, acute form of delirium, or a state preceding degenerative changes of a permanent nature or death (Engel).²

The clinical syndrome of delirium is the outstanding syndrome of a cognitive disorder. Other syndromes such as epileptic seizures, syncope, states of perplexity, stupor and coma are sometimes more serious manifestations of cortical disorder, but less likely to produce as much distress in caretakers. The diagnostic criteria for delirium which are generally accepted are worth repeating in the interests of clarifying the syndrome being referred to here. In delirium the individual is awake and responds to external stimuli although responses may indicate that the messages are undergoing distortion; perception, attention, memory, and thinking, and behaving are impaired but fluctuation in the degree of impairment is evident over a period of time; defective reality testing is evident and past experience and knowledge are not used in a predictable manner when responding to stimuli in the environ-

ment. The syndrome of delirium may last from a few seconds to months and may be followed by seeming total recovery, residual amnesic states and dementia, or progress to stupor, coma, and death.

Treatment

Although a patient in coma is not reactive to oral stimuli, not uncommonly the individuals responsible for the care of patients in varying states of clouding of consciousness overlook the extent to which patients going into or coming out of states of stupor or coma are capable of receiving and comprehending stimuli. Of importance is the fact that the individual with clouding of consciousness can be contacted by spoken stimuli which can affect him adversely or favorably. The author³ has previously recommended general steps to be taken to favorably influence the patient in poor contact with the environment. The patient's room should be lighted brightly; during the night the lights should be on; spoken stimuli should be direct and forceful and should penetrate the barriers against perception—"Sit up and drink this water"—rather than a quietly spoken—"Would you like a drink"—should be used; stimuli which cast shadows and barely penetrate the perceptual barriers or those which form a background for reverie are undesirable; human contacts should be as frequent as possible and forceful enough to bring a message that "this is human contact outside of me and not in my dreams."

Feeding into the patient alerting, orienting and attention catching stimuli and information through confronting him with reality based data in a forceful, succinct verbalization is the psychotherapeutic element in treatment. The prodding question—"What do you think or feel about what I told you?"—is not used until the patient's state warrants the testing of his capacity to deal with a problem-solving and decision-making request. The patient is confronted with: "This is a nice day, the sun is shining brightly."—"I have a glass of orange juice for you!"—"Monday is the visiting day, and I understand your wife is coming today."—"How do you feel on this March 21, the first day of Spring?" Contacts should be as frequent and lengthy as possible. The therapist should be capable of functioning as a "programming

machine" in which the voice tones of human kindness, helpfulness and interest are present to add not only information, but hope. Confrontation statements directed at control of regressive behavior followed by—"What do you think or feel about what I told you"—are introduced as the potentiality for using the will to control and regulate behavior seems to be within the grasp of the patient. For instance, for the patient who continues to be incontinent—"I want you to be," or "you can be a clean person. What do you think or feel about what I told you?"—may have significant effects in a relatively short time. An improved relationship with personnel follows thereupon with a positive feedback value for the patient (Garner).⁴

Restoration of Equanimity

An awareness of the disturbed perceptual functions is a major distressing element in the patient's maneuvers to restore equanimity. The compliant attitudes of the patient to authoritarian commands plus the question—"What do you think or feel about what I told you"—usually create an awareness of the helper as a benevolent person who expects the patient to have the capacity for functioning on the basis of realistic perceptions of the universe. The therapist introduces confrontation problem-solving statements directly aimed at the perceptual distortions, thought disorder or behavior. Repetition of the statement at frequent intervals during the therapist's contacts can be supplemented by such repetition by all other personnel in contact with the patient.

It is hoped that the essential elements such as—disorientation,—grasp (the ability to comprehend relationships among the elements in the environment and to relate them to oneself and one's past experience),—attention (that selective central influence which determines which aspect of or which stimulus object will be responded to) will be affected by the intruding confrontations which the patient will find difficult to evade because of their repetitive quality and the evident invitation to the patient to return to real human contact.

Thinking processes are disordered in the clouding of consciousness. Hilgard⁵ describes two basic types of thinking as be-

ing associative thinking as in reverie and dreams and directed or critical and creative thinking. The aspects of directed thinking are generally conceived of as organization of material for purposes of problem-solving and communication; dynamics (the evolution and progression of thought) and the content and concept-formation. The confrontation statements are seen as interfering with the reverie and dream-like associative thinking of the clouded consciousness and as demanding an effort at directed thinking. They may be used to direct attention to the disrupted or fragmented organization, defective reasoning with disregard of logic, the content of bizarre thoughts, images and fantasies. As some improvement occurs, the dysfunction in problem-solving and purposive behavior is used in selecting a confrontation intended to stimulate awareness of the need to use directed attention in controlling the thinking process—"You should think like the ordered and sensible person you can be"—"Stop thinking and behaving like a mixed up person"—"Use the good sense you have in your thinking"—are examples. One may respond to the paranoid delusional content, often a frightening nature—"Stop believing terrible things are happening all around you and that someone is harming you. What do you think or feel about what I told you?"

It is necessary to emphasize that the patient is showing a decreased capacity to focus on the influencing factors in the environment. However, the influence of stimuli which tend to penetrate the sensory barriers, especially that provided by human contact, is considerable. The feeling of a need for help and the response to appropriate contacts which emphasize the approach of help is evident in the verbalizations of patients in delirium. Confrontations penetrate the sensory barrier, they are recognized as an attempt at help, they awaken feelings of reassurance associated with the awareness of the arrival of help when one is in desperate straits. Lipowski,⁶ in the paper referred to above, calls attention to the fact that Hartley recognized these facts over 200 years ago when he noted that the patient in de-

(Continued on page 82)

Rx Products Index

Achrocidin28	Librium18-19
Lederle Laboratories	Roche Laboratories
Achromycin 3rd cover	Lomotil 2nd Cover
Aventyl HCL14-16	G. D. Searle & Co.
Eli Lilly and Company	Mucomyst24-25
Butazolidin86-87	Mead Johnson Laboratories
Geigy Pharmaceutical Corp.	Mylanta6
Bayer Aspirin23	The Stuart Company
Glenbrook Laboratories	Neo-Synephrine (Pediatric)4
Dicarbosil98	Winthrop Laboratories
Arch Laboratories	Obedrin-LA715L3
Dienestrol22	Semed Pharmaceuticals
National Drug Company	Quinamm/AVC21
Dimetapp79	National Drug Co.
A. H. Robins Company	Tepanil11
Empirin Compound7	National Drug Co.
Burroughs Wellcome & Co.	Thera-Combex HP13
Equanil26-27	Parke Davis & Co.
Wyeth Laboratories	Urisid29-30
Ilosone32	Conal Pharmaceuticals, Inc.
Eli Lilly and Company	Vasodilan CVD8-9
K-Lyte76-77	Mead Johnson Laboratories
Mead Johnson Laboratories	Valium Back Cover
	Roche Laboratories

PSYCHOTHERAPY IN SCHIZOPHRENIA

However, recent research by Philip May in California, reported in book form this year, after ten or more years of work, has compared in a reasonably satisfactory design, on equivalent groups of cases, the relative efficacy of five of our major therapeutic modalities.

May studied the effect of the following treatments on so-called "middle prognosis" hospitalized schizophrenic patients: 1) psychotherapy 2) ataractic drugs 3) psychotherapy plus drugs 4) electric shock treatments and 5) milieu therapy. I will not go into the technicalities of the research design except to say that after carefully controlled work, and very intensive treatment, May found that ataractic drugs were effective with these schizophrenics; that electric shock was less effective; that psychotherapy and milieu therapy were least effective, and that psychotherapy added essentially nothing to the therapeutic benefits afforded by ataractic drugs. In other words, there was no significant interaction between psychotherapy and ataractic drugs.

May's studies will shock some people who have used psychotherapy on schizophrenic patients for long years and depended on it as an "effective measure." Unfortunately, in many instances they should have been using ataractic drugs. (Milton Greenblatt: Control Versus Treatment Of The Troubled Mind, **Medical Counterpoint** [Sept.] 1969; pp. 50-57.)



ALL THE NEWS THAT FITS, Herman H. Dinsmore, Arlington House

The current selection for the Public Affairs Library Book Review is particularly timely following two recent speeches made by Vice-President Agnew, when he lashed the Eastern Establishment press.

ALL THE NEWS THAT FITS, is a unique analysis of the news and editorial content in the *New York Times*.

The author, Herman Dinsmore, joined the *Times* back in 1929 when the newspaper was building its reputation for greatness. By 1951 Mr. Dinsmore was editor of the International Edition, a post he held until 1960. Now he gives his frank opinion as one who views it from the inside—and with interesting results.

Mr. Dinsmore spells out the four ways that the press slants or suppresses the news it finds incompatible with its goals of enlarging the central government. He displays a wealth of news items that missed

every edition of the *Times*.

An old pro at news reporting, Mr. Dinsmore has written a book that reads like a history of our time. Obscure pieces of information are the order of the day. They provide a graphic illustration of how news is shaped and formed by carefully pre-selected editors and writers.

It is writings like this that tend to shape the news the way it really is, not how someone wants it to be—one sided, incomplete, slanted, and invariably in support of large central governments here and abroad, including pictures and news to make America look bad and our enemies look good. Dinsmore sets the record straight.

Three hundred seventy-six pages, a four page bibliography and an exhaustive 18 page index are a part of ALL THE NEWS THAT FITS. Available from ARLINGTON HOUSE, 81 Centre Avenue, New Rochelle, New York, 10801. \$7.00 per copy.

SPIRALING COSTS OF MEDICAL BOOKS

The *British Medical Journal* recently published a series of articles and a leading article on the vexed question of the rising cost of medical publications. Clearly, the persistent inflationary spiral must affect the cost of scientific publications, but there seems to be a danger that some books, particularly monographs on specialized subjects and volumes recording the proceedings of conferences, may price themselves out of the reach of many for whom they are intended. Pyke commented on the fact that experienced reviewers are beginning to remark adversely on the high cost of the books submitted for review, often suggesting that only libraries will be able to afford to buy them. Even allowing for the fact that certain types of books can only have a small demand and consequently must be expensive, Dr. Pyke suspects that a minority of publishers have been overpricing their publications, although the majority have been trying to control the upward trend.

Green, who is both a physician and a medical publisher, admitted that medical books are dear, but not too dear for people to buy. He pointed out that in the last 10 years, the cost of printing has risen by 70 per cent, that of paper 30 per cent, and that of binding another 30 per cent. Furthermore, the publisher always accepts a considerable risk, and the rapid advances of modern medicine have reduced the useful life of a book to such an extent that a revised edition is often required before the first edition has been cleared. He could see no way of reducing the present cost of medical books. (John Lister: *By The London Post* . . . Cost of Medical Publications. *New Eng. J. of Med.* (Medical Intelligence) 281:18 [Oct. 30] 1969.)

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16	3.50	4.40
25	4.52	4.47

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Precautions: Should not be used in patients with low urinary output unless under the supervision of a physician. In established hypokalemia, attention should be directed toward correction of frequently associated hypochloremic alkalosis and other potential electrolyte disturbances. Patients should be directed to dissolve tablet in stated amount of water to assure against gastrointestinal injury associated with the oral ingestion of concentrated potassium salt preparations.

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How Supplied: Effervescent tablets—boxes of 30 and 250 (orange or lime).

*Reports on file: Medical Research Department, Mead Johnson Laboratories, Evansville, Indiana 47721

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Meeting Memos

Jan. 29-31—University of Kentucky, College of Medicine

Symposium

University of Kentucky, Albert Chandler Medical Center, Lexington, Ky.
"Modern Methods for the Medical Work-Up"

Jan. 31—Illinois Heart Association

"Heart Is Our Cause"
Holiday Inn East, Springfield

Feb. 4-5—The Cleveland Clinic Educational Foundation

Postgraduate Course

2020 East 93rd St., Cleveland, Ohio
"General Practice"

Feb. 6-7—Illinois Society of Anesthesiologists

Applied Science Seminar

University of Chicago, Center For Continuing Education

Feb. 7-14—College of American Pathologists

Interim Meeting

Shamrock Hilton Hotel, Houston, Texas

Feb. 7—Chicago Surgical Society

Scientific Program

76 E. Monroe St., Chicago

Feb. 8—ISMS Seminar—Peer Review; Malpractice

Sheraton—Blackstone Hotel, Chicago

Feb. 8-10—American Society for Aesthetic Plastic Surgery

Marriott Motor Hotel, Atlanta, Ga.

Feb. 8-9—AMA Council on Medical Education

66th Annual Meeting

Palmer House, Chicago

Feb. 10-13—University of Iowa, College of Medicine

Refresher Conference For General Practitioners

University of Iowa, Iowa City, Iowa

Feb. 11—Frontiers of Medicine—1970

Abnormal Uterine Bleeding and Pain

University of Chicago, Hospitals & Clinics
950 East 59th Street, Chicago

Feb. 12—The Institute of Medicine of Chicago

Forum on Health Topics

Lawson YMCA, Chicago
"Stress and Tension"

Feb. 14-18—American Academy of Allergy

Jung Hotel, New Orleans, La.

Feb. 16—Disease Detection Information Bureau of Chicago

Workshop

Sheraton-Dallas Hotel, Dallas, Texas

Feb. 16-18—American College of Surgeons

Sectional Meeting

St. Paul Hilton, St. Paul, Minn.

Feb. 17—Chicago Pediatric Society

Pediatric Dermatology

Chicago

Film Reviews

The Health Careers Council of Illinois is now offering a new health careers film list in which over 50 films representing 20 health occupations are catalogued. Available to those who provide career guidance to young people, it may be secured by writing: HCCI, 400 North Michigan Ave., Chicago 60611.



A new film emphasizing how to minimize athletic injuries is now available for viewing by coaches, school administrators, parents and athletes, as well as physicians. Entitled, "The Team Physician,"—the 16mm sound-color film running 28-minutes—is available from Films Section, American Medical Association, 535 N. Dearborn, Chicago 60610.

"How To Complete A Certificate of Live Birth" is the title of a new film strip recommended for viewing by registrars, medical students, health officials, medical record librarians and nurses. Write: National Medical Audiovisual Center (ANNEX), Station K, Atlanta, Georgia 30324.



The technique of intra-articular and peri-articular injection of corticosteroids in treating arthritic patients is shown in a new film produced by the Upjohn Company. The 20-minute full color film titled "The Technique of Intra-Articular and Peri-Articular Injection," is available without charge to members of the medical and related professions. Write: Upjohn Film Library, Kalamazoo, Michigan.



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Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

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Successful Pregnancy

In a Woman

With Severe Uremia

BY MARIA H. BALKOURA, M.D., MARUTI S. BHORADE, M.D.
SHELDON M. KAHN, M.D., AND GEORGE DUNEA, M.B./CHICAGO

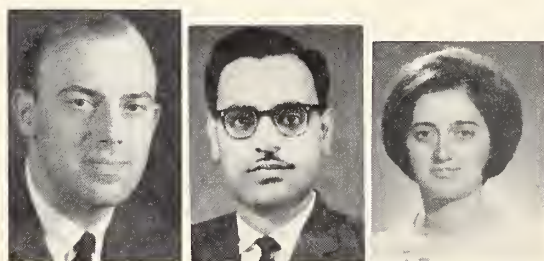
Uremia is a common cause of fetal death and delivery of a viable infant is unusual in patients who have even mild impairment of renal function.¹⁻⁵ It is therefore of interest to record the case of a woman who presented with severe uremia and who gave birth to a normal infant.

Case Report

A 34-year-old Negro woman, gravida IX, para VIII, was admitted to hospital on 12-21-67 because of abdominal cramps and vaginal bleeding of one days' duration.

The patient was 36 weeks pregnant. She had noticed moderate pedal edema during the two months before admission to hospital and had experienced occasional nausea and vomiting. Although a poor historian, she denied any other symptoms and claimed she had been well during the earlier months of her pregnancy. There was no past history of hypertension or renal disease. She had been treated for pulmonary tuberculosis in 1959 and for possible phlebothrombosis in 1962. The patient had gone through eight uneventful pregnancies, the last of which occurred three years prior to admission.

The patient was an obese woman in no apparent distress. B.P. was 160/100 mm Hg. Slight arteriolar spasm in the fundi, moderate cardiac enlargement and pulmonary congestion were noted. The abdomen was not tender, the uterus appeared to be about 36 weeks pregnant. The fetal heart tones were 140 per minute and there was moderate pitting edema of both legs. The urine contained much protein—(4 gms. per 24 hours), 3-4 white cells and 10-15 red cells per high power field. The hematocrit was 20%, hemoglobin 7.6 gms. per 100 ml. and the white cell count 7,900 per c. mm. Blood urea nitrogen was 114 mg. 100 ml. and serum creatinine 9.5 mg. per 100 ml. Serum sodium was 125, serum chloride 96,



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potassium 5 and CO₂ combining power 5.9 mEq. per liter.

The day after admission the patient was delivered spontaneously of a premature baby boy who weighed 3 lbs. 9½ ounces and was rated as Apgar #8. The placenta was 8 cm. in diameter and had several areas of degeneration. Although the baby was premature, the subsequent course was satisfactory and there were no complications.

Following delivery, the patient was investigated to determine the cause of her renal disease. She had a normal coagulation profile and no evidence of systemic disease. Urine cultures were negative for acid fast bacilli and other organisms. The retrograde pyelogram showed small renal shadows, a normal left ureter and collecting system, but some dilatation of the right ureter and collecting system. X-ray revealed moderate cardiac enlargement and no evidence of uremic osteodystrophy.

Following delivery the patient maintained a urine output of approximately 1,000 ml. per 24-hours but became increasingly azotemic. BUN rose to 180 mg. per 100 ml. and serum creatinine to 17 mg. per 100 ml. Convulsions occurred on 1-25-68 and peritoneal dialysis was begun. In the subsequent weeks she again became uremic and had three further dialyses. No return of renal function occurred and the patient died on 3-21-68 of uremia.

Necropsy Findings

The kidneys were small, weighing 120 gm. (Rt.) and 100 gm. (Left) and measuring 9 cm. in length (Rt.) and 8 cm. (Left). The capsule stripped with difficulty. The renal surface exhibited uniform granularity. The granular areas measured about 0.3 cm. in diameter and there were no deep scars. The right ureter was mildly dilated and there was some dilatation of the pelvis and calyces.

Microscopically, most glomeruli were completely or partially fibrosed. A few non-fibrosed glomeruli showed some prominence of epithelial cells. No periglomerular fibrosis was seen. Tubules were atrophic and often dilated, especially around the partially fibrotic glomeruli. There was diffuse interstitial fibrosis with lymphocyte and plasma cell infiltration. The arterioles and small arteries showed reduplication

of the elastica.

The heart weighed 480 gms. There was fibrinous pericarditis and left ventricular hypertrophy and dilatation. The valvular orifices were normal in size, but the cordae tendinae were thickened and partially fused by old rheumatic process. Along the lines of closure of the mitral and aortic valves there were verrucous changes consisting of amorphous material; this was interpreted as non-rheumatic, non-bacterial verrucous endocarditis.

The lungs were congested. There were areas of bronchopneumonia and uremic pneumonitis. A sterile smooth cavity at the left apex was in communication with a stenosed bronchus. Acid fast bacilli and caseation were not seen.

The liver was enlarged (1,800 gms.) and exhibited mild fibrosis of portal fields. Hemosiderin was present in large amounts in the Kupfer cells and hepatocytes. Iron was not found in other organs.

The spleen was large, passively congested and had a few old infarcts. There was uremic colitis, a small duodenal ulcer, moderate hyperplasia of the adrenal cortex and of the parathyroid glands.

Comment

Although much remains unknown about renal disease in pregnancy, most authorities would regard the occurrence of renal insufficiency as an unfavorable prognostic sign for both mother and fetus.¹⁻⁵ Not only is delivery of a viable infant most unlikely, but further deterioration of renal function may occur and cause death of the mother during or after the pregnancy.

It would appear, however, that in rare instances, successful delivery is possible even in the face of significant azotemia. In a recent report, Kinkaid-Smith and associates refer to three patients with polycystic kidney as well as to a fourth patient, who gave birth to viable infants at a time when BUN ranged from about 100 to 250 per 100 ml.²

Our patient further illustrates that successful delivery of a normal infant may occur in the presence of severe uremia. BUN was 114 mg. per 100 ml., serum creatinine was 9.5 mg. per 100 ml. and peritoneal dialysis had to be instituted within 34 days after delivery. The patient had a renal

(Continued on page 93)

— THE VIEW BOX —

(Continued from page 52)

DIAGNOSIS:

Radiation Scoliosis and Colitis resulting after surgery and radiation therapy of a Wilm's Tumor of the right kidney 21 years ago.

In irradiated tumor the degree of vertebral change depends on the amount and character of the radiation. This patient received ortho voltage (3000 R.T.D.). Skeletal changes will not be seen until at least a year following the radiation.

Neuhauser mentions three types of changes:

- 1) Horizontal transverse lines of increased density parallel the epiphyseal plate "os in os" appearance usually occurring in the dose range of 1000-2000 R.
- 2) Irregularity and scalloping of the vertebral plates associated with a loss in axial height, more pronounced trabeculation, and severe changes in growth pattern. The disc spaces are unchanged. The articulation at the pedicles may be abnormal. These changes require 2000-3000 R to be produced.
- 3) Our case demonstrates the third type of change which is similar to osteochondrodystrophy or achondroplasia. Growth is most markedly retarded and the vertebrae appear flat and beaked. They are considerably reduced in size within the radiation portal. There are irregularities at

zygo-apophyseal articulation as well as loss in the disc space height. Dose required is 2500 R or more.

Other changes occurring:

There is decrease in the interpediculate space with resultant narrowing in the size of spinal canal especially in the lumbar area. Growth will be depressed with resultant hemiatrophy if the iliac bone apophysis is in the radiation portal. The sacroiliac joint is widened due to undergrowth of ilium with reduction of size of sacrum in some cases. Lower thoracic ribs may also be under developed if included in the treatment area.

The therapist can help if he (1) avoids the iliac crest and (2) avoids the femoral head. The importance of including the entire vertebral body within the treatment part is a matter of debate.

The mucosa of the gastro-intestinal tract is extremely radiosensitive and ulceration may result in repeated severe hemorrhages, and fibrosis involving a large segment of colon.

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Confrontation Techniques

(Continued from page 73)

lirium who has been in the dark will stop hallucinating when a candle is lit. The confrontations noted and others of a similar nature will offer more than a candlelight of reassurance. The repetitive contact which is part of the treatment method has the tendency to alert, make the patient aware that he can choose to respond to external rather than internal stimuli, and demands action in a reply by the question—"What do you think or feel about what I told you?"—which furthers the reality

based interaction of the delirious patient.◀

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SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

BY JOSEPH J. LOTHARIUS

ISMS Leadership Conference Spotlight on Malpractice & Peer Review

Malpractice and peer review—the two most crucial issues facing MDs today—will share the spotlight at the 1970 Leadership Conference Sunday, February 8, at Chicago's Sheraton-Blackstone Hotel. (See agenda on page 44). Because malpractice and peer review are of such vital concern to the financial and professional future of every physician, ISMS members are urged to attend the Conference. Conference Chairman Dr. Jacob E. Reisch said "recommendations for avoiding malpractice suits and guidelines for setting up effective peer review mechanisms on the county level will be presented." The Conference will be open to ISMS members only.

AMA Delegates Reject ISMS Request to Raise Medicaid Payments

An ISMS resolution requesting that Medicaid payments in the state, currently frozen at approximately the 60th percentile of usual, customary and reasonable fees, be raised to the level of Medicare payments, currently being paid at approximately the 83rd percentile, was rejected by AMA delegates at the meeting in Denver. The AMA Reference Committee recommending rejection pointed out that the ISMS resolution would require a change in the federal law. This would give HEW authority to establish levels of payment in state programs and further erode the authority of the states. The Reference Committee also stated "it is basic policy of AMA that all government programs purchasing medical care should pay for such services on a usual, customary, or reasonable fee basis and that continued action toward this goal at the national and state level seeks the same end—equality in care—without such a statutory change."

AMA Approves Wider Distribution of Med Students

Another ISMS resolution, which called for a wider distribution of med students, interns and residents in non-medical school affiliated hospitals, was approved by AMA delegates. The resolution further asked that "educational experience, where feasible and practical, expose these trainees to the merits of practice under a variety of environmental circumstances."

Plans to Improve Ghetto Health Care

Plans for a pilot project to improve medical care in the ghetto was to be studied by the Board of Trustees this month. The plan—suggested by Dr. Andrew Thomas, president of the Cook County Physicians Association—would have IDPA recognize higher “usual, customary and reasonable fees” from specialists working in the ghetto than general practitioners. According to Dr. Thomas, many specialists are not accepting public aid patients because IDPA is not recognizing their fees. “While we cannot hope to attract more specialists to the ghetto with increased IDPA payments,” Dr. Thomas said, “we would like to retain the few that we have for consultation purposes.” If the ISMS Board of Trustees approves the plan, IDPA would consider implementing it immediately for a “pre-determined period of time.”

One Bill for Surgeon and Assistant Requested

ISMS Board members will consider a recommendation from its Usual & Customary Fees Committee that IDPA recognize the total bill of a surgeon who includes the cost of the assisting surgeon providing the surgeon's bill reflects payment to the assistant. The present IDPA policy requires surgeons and assisting surgeons to submit separate bills. It was felt the single billing would be more convenient for all parties.

YOUR ISMS INSURANCE QUESTIONS

QUESTION: Is partnership or corporation coverage available under the ISMS approved malpractice program?

ANSWER: Coverage for either the partnership or the corporation is available provided all members of the partnership or corporation are insured for identical limits by the program's Professional Liability insurer. There is no additional charge for this provision when the above outlined requirements are met.

Do you have a question of general interest on any ISMS-sponsored insurance program: Retirement Investment, Keogh, Group Disability, Group Major Medical, Professional Liability (Malpractice)? Send it to this column: "Your ISMS Insurance Questions," Illinois Medical Journal, 360 N. Michigan Avenue, Chicago, Ill. 60601. The column is a service of the ISMS Committee on Medical Economics and Insurance.

Economic Discomfort Ahead Viewed as Acceptable

"The view ahead is now clear but the road is not. We have pretty well moved past the deep ditches and massive boulders on the road to stable growth and we are now faced only with obstacles that one could characterize as pebbles and potholes. There is still ahead of us some discomfort, but nothing that a sturdy and healthy economic machine can't negotiate with an acceptable level of discomfort. There is no reason for us to have to go back over the same road again."—Dr. Maurice Mann, assistant director, Bureau of the Budget.

"Doing for people what they can and ought to do for themselves is a dangerous experiment. In the last analysis, the welfare of the workers depends upon their own initiative."—Samuel Gompers, first president of the American Federation of Labor.

Sandy sails again! After an arthritic flare-up.

His rheumatoid arthritis flared out of aspirin control.
It meant weeks of pain, stiffness,
swelling and tenderness...and a lot of sun and wind that
somebody else took advantage of.

Next time, after aspirin, consider Butazolidin alka:
prompt anti-inflammatory effectiveness
short trial period
low maintenance dosage
usual dosage: 1 capsule q.i.d. initially, then 1 or 2 daily

Butazolidin[®] alka

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Serious side effects can occur.
Select patients carefully (particularly the elderly) and follow them
closely in line with the drug's precautions, warnings and contraindications. Read the prescribing information. It's summarized below.

s, Stevens-Johnson syndrome, all's syndrome (toxic necrotizing dermatolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis is rare, rarely, salivary gland enlargement may require cessation of treatment. Such patients should not receive subsequent courses of the drug. Vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot

be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angitis, pericarditis and several cases of anuria, glomerulonephritis and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Rheumatoid Arthritis:
Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week.

Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily. In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (B)46-070-C
For complete details, please see full prescribing information.

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If it doesn't work in a week, forget it.



WHY SHOULD I JOIN?

EVELYNNE WALTER, C.M.A./McHENRY

One of the continuing goals of the Illinois Medical Assistants Association is to enlarge the membership. As in any organization, this is a challenging and often frustrating experience. This important position automatically becomes the job of the Vice Presidents. They and their committee must devote endless hours devising methods to attract new members. Their problems are many.

Why should I join? Perhaps this is the question most often voiced by prospective members. Other words may be used but convey the same meaning. "My doctor is satisfied with me just the way I am." "I have been with my doctor for ten years and I know exactly how he wants his office run." Basically the speaker wants to know the same thing, "How will joining the Illinois Medical Assistants Association benefit me?"

Why should I join? The benefits are many. The regular monthly meetings held in every County Chapter of I.M.A.A. offer an excellent opportunity to hear lectures given by professional people in various walks of life. Doctors, Lawyers, Registered Nurses, Representatives of Drug companies, and Therapists, just to mention a few. Even though many medical assistants work for doctors specializing in one field of medicine, attending lectures given by professional people in other areas gives her the opportunity to broaden her knowledge and proves to her physician employer that she has an ambition and interest in pursuing self-education, thus making her a more complete person.

Educational symposia are offered at intervals throughout each year. These symposia are designed to offer the medical assistant the opportunity again to broaden her knowledge and interests. These day-long programs include speakers on Medicare, Medico-legal aspects encountered in the office, Medical Ethics, Public Relations,

Officer management, personal grooming, telephone manners, bill collecting, and the list could go on and on, to include doctors speaking about their specialties or the clergy talking about the relationship between medicine and religion.

Each year during the month of April, three days are set aside for the annual meeting of the Illinois Medical Assistants Association. Medical assistants from all over the state of Illinois come together to attend lectures, participate in workshops, take care of the legislative business necessary in any organization, and to get together with other medical assistants to exchange ideas and experiences. Communicating with others during these three days, attending lectures and sitting in on workshops cannot help but send each medical assistant back to her office with a sense of being renewed. Her doctor will become aware of her enthusiasm and perhaps will manage time for discussion regarding information and new ideas she has brought back with her. Again he must appreciate the fact that she cared enough to enlarge her outlook thus increasing her efficiency and loyalty to him.

Year after year the Membership chairmen and their committee will **strive** to recruit new members, as will all the members of I.M.A.A. With the answering of the question, "Why should I join?", we hope to convince the medical assistant voicing it, of the extremely beneficial educational aspects of I.M.A.A. Thus, too, we hope to gain the understanding and support of her doctor employer.

If you are interested in membership in this organization, please contact either Mrs. Vivian Johnson, First Vice-President, 9105 S. Albany, Evergreen Park, Illinois 60642 or Mrs. Mary Siers, Second Vice-President, 801 North 84th Street, East St. Louis, Illinois 62203.

The Medical Aspects of

Professional Baseball

JACOB R. SUKER, M.D./CHICAGO

The team physician for a professional baseball team is faced with a variety of medical problems on a daily basis. It is a unique and often times an exciting experience. On any given day he may be required to treat a sore throat, listen to the latest physiologic explanation for a batting slump, comment on the medical report of a player to be obtained in a trade or learn that his team has just concluded a series in a city that has an epidemic of encephalitis. During the season his potential patient pool consists of 25 players, 4 coaches and a manager from his own team and a like number from the visiting team. In addition to the major league teams, he is responsible for the medical care of four umpires and the administrative staff of the organization. He is also the consultant to all the minor league affiliates of the major league club. The Chicago Cubs have affiliates in Tacoma, Washington; San Antonio, Texas; Coldwell, Idaho; Quincy, Illinois; and a winter league camp in Scottsdale, Arizona. These teams have a total compliment of 140 players and coaches.

The medical staff consists of a trainer with each team, the team physician and a panel of consultants in all the specialties. In addition to their interest in sports medicine and professional competence, this team must have a close rapport with the players and administrative staff.

This year professional baseball celebrated its 100th anniversary and during this period it has had sufficient time to develop certain distinctive features. Of interest to the physician is the baseball dialect. Many players have attended college and some are enrolled in graduate schools. However, when they report to the minor leagues they seem to acquire the traditional expressions used in their daily communications. By the time they have developed their athletic skills and join the major league team they have an extensive anatomic vocabulary which can be thoroughly confusing to the uninitiated. The stomach becomes the boiler, the throwing arm the hose, the eyes lamps, the legs wheels, the malingerer a jaker, the player who is a bit odd is flakey and the player who always has adhesive tape showing is referred to as a Johnson and Johnson. When a player is undressed he has had a hummer (fast ball) thrown at the middle button of his uniform shirt by the pitcher. The team physician rapidly acquires a facility for this dialect and utilizes it in establishing rapport with the players.

In the recent expansion of the major

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** This is the first in what the Illinois Medical Journal hopes to be a continuing series on the "Medical Aspects of Professional Sports."*

leagues the new teams paid 10 million dollars each for the personnel they obtained from the other teams. This is indicative of the relative monetary value of the professional talent. The team physician is therefore expected to provide the facilities and services required to practice preventative medicine. This is accomplished by having all new players undergo a complete physical examination, blood counts and urinalysis during spring training in Scottsdale, Arizona. At the completion of the regular season all major league personnel have a complete physical examination, blood counts, urinalysis and chest X-ray. Where pertinent such information is communicated to their personal physician.

In order to illustrate the variety of medical problems encountered in professional baseball players, coaches, manager and umpires, I have listed below some of the disorders seen by our staff in the past seven years.

I. Central Nervous System

- A. Concussion
- B. Convulsive Disorders
 - 1. Post-Traumatic
 - 2. Etiology undetermined

II. Endocrine and Metabolic

- A. Diabetes Mellitus
- B. Gout
- C. Rheumatoid Arthritis
- D. Heat Exhaustion

III. Infectious

- A. Bacterial
 - 1. Streptococcal Pharyngitis
 - 2. Otitis Media
 - 3. Otitis Externa
- B. Viral
 - 1. Pharyngitis—presumably viral
 - 2. Infectious Mononucleosis
 - 3. Gastro-enteritis
 - 4. Mumps Parotitis
 - 5. Mumps Pancreatitis without Parotitis
 - 6. Infectious Hepatitis
- C. Fungus
 - 1. Dermatophytosis
 - 2. Tinea Cruris
- D. Parasites
 - 1. Amebiasis
- E. Unclassified
 - 1. Reiter's Syndrome
 - 2. Prostatitis

3. Urethritis

IV. Neoplasms

- A. Mixed Tumors of Parotid
- B. Lipomata
- C. Basal Cell Carcinoma

V. Cardiovascular

- A. Aortic Stenosis
- B. Coronary Insufficiency
- C. Paroxysmal Atrial Tachycardia

VI. Collagen Diseases

- A. Vasculitis

VII. Gastrointestinal Disorders

- A. Gastro-intestinal Hemorrhage due to duodenal ulcer
- B. Hiatal hernia

VIII. Ocular Problems

- A. Astigmatism
- B. Color-Blindness

IX. Surgical Entities

- A. Acute Appendicitis
- B. Foreign Bodies
- C. Lacerations
- D. Fracture of Zygomatic Arch
- E. Fracture of Mandible

X. Psychiatric

- A. Anxiety Reaction—usually associated with injury
- B. Depressive Reaction

XI. Hematologic

- A. Sick Cell Trait
- B. Myelogenous Leukemia

XII. Dental

- A. Dental Abscesses
- B. Ulceromembranous Stomatitis

XIII. Non-Orthopedic Injuries

- A. Traumatic Epididymitis
- B. Scrotal Hematoma

XIV. Drug Reactions

- A. Exfoliative Dermatitis

Central Nervous System Disorders

The wearing of reinforced plastic helmets has decreased the incidence of serious head injury. However, from time to time players will sustain a concussion either from a pitched ball or collision. It is our

policy to hospitalize all players who have had an episode of unconsciousness or demonstrate a period of confusion following head trauma. The player is hospitalized for at least 48 hours and kept out of the line-up for another 24 hours or longer as dictated by the clinical findings. It is important to emphasize that maximal cerebral edema occurs at 48 hours and premature return to activity will expose the player to further injury at the plate if there are minor transient changes in reflex action, depth perception or diplopia.

Most all baseball players have participated in contact sports in high school and/or college. We have seen some players who have a convulsive disorder either from previous head injuries or of undetermined etiology. This is an especially difficult problem since the occurrence of seizures is not predictable, especially the petit-mal type with its transient confusional state. The consequences of such an episode occurring during batting or pitching are obvious. Control of the frequency and intensity of seizure activity can usually be achieved with appropriate therapy. Failure to achieve such control is sufficient reason to recommend discontinuing baseball as a career.

Endocrine and Metabolic Disturbances

The most challenging metabolic disorder in the young athlete is diabetes mellitus. It is apparent that diabetics who can successfully play high school baseball are not very brittle. Consequently, the diabetic in professional baseball represents a small fraction of juvenile diabetics who are relatively easily controlled with insulin and diets. These diabetics require special instruction and dietary manipulation because of the varying intensity of physical activity in extremes of environment, the altered meal schedules due to night games and travel. Several years ago we studied the activity pattern of the various positions on the team. Pedometers were utilized on selected personnel and our results would indicate that the range of distance covered by a player is 4-8 miles from the time he leaves the clubhouse for pre-game workouts to his return after the game. A majority of this distance is covered while running or jogging and is influenced by the location of the dugout, his

position and the number of total bases he has in a game. It is therefore obvious that control of diabetes in any professional baseball player should be highly individualized and insulin reactions are to be avoided.

Gout is a rather infrequent finding in professional baseball players. Our experience has been that if it occurs it will do so in older players, especially pitchers and will aggravate a pre-existing calcific tendonitis. Rheumatoid arthritis when it occurs in young players carries a poor career prognosis and most often is characterized by spondylitis.

We have not had any difficulty with the heat exhaustion syndrome. During a nine inning game in a hot humid stadium players will lose 5 to 8 pounds of weight. The failure to develop the heat exhaustion syndrome we feel is due to two factors. The first is that the syndrome is a failure of adaptation to environment and as such occurs early in training in a hot humid environment. Our spring training is conducted in Arizona in a low humidity environment and at the start of the season the players are fairly well heat-adapted. Secondly, during periods of high heat stress during the season all regular players take two salt tablets at the end of each inning. Some players require additional amounts of salt depending on their weight. In the past decade we have had only occasional cases of heat exhaustion and no heat stroke.

Infectious Diseases

Our most common bacterial infections have been streptococcal pharyngitis presumably contracted from children at home and otitis media and externa. Ear infections pose a real problem since all teams travel by air. We do not allow players to fly when there is an acute ear infection.

Viral infections are commonly those involving the respiratory tract and limit the player's physical capacity if swelling and obstruction of the upper passages lead to mouth breathing. Infectious mononucleosis with splenomegaly is of special concern if it occurs in an infielder or catcher who has greater occasion for body contact.

Psychiatric Problems

We have not observed any overt psychoses in our treatment of the professional

athlete. However, the athlete places a rather high value on physical fitness and any injury which threatens his career and livelihood gives rise to numerous anxieties which are manifested in a number of ways. The recognition of the anxieties requires excellent confidential rapport with the player. Treatment of the injury and supportive psychotherapy are often all that is required to get the player back into the line-up in a reasonable period of time.

There has recently been a great deal of discussion in the lay press about the doping of high school, college, olympic and professional athletes. Doping consists of the use of any chemical substances not normally present in the body and not essential to a healthy person competing in athletics. The most commonly used classes of drugs appear to be analgesics, ergogenics and tranquilizers. There is evidence that amphetamines can drive trained athletes to increased performance in situations that involve sustained effort. They are not a source of additional mental or physical prowess and often lead to dangerous fatigue and therefore potential injury. Furthermore, in some individuals these drugs have dependence-producing characteristics and can lead to serious clinical and personal problems. With the protracted travel schedules and rare "off days" there is a great temptation for professional baseball players to resort to amphetamines. The almost universal availability of these drugs does little to minimize this problem. Our medical staff recognizes that there are definite medical indications for the use of amphetamines. Fortunately, we have not encountered any of these indications while treating members of our team. We therefore discourage the use of any medications by players unless they are prescribed by the medical staff.

The team physician is in charge and bears the primary and overall responsi-

bility for maintaining the team roster and 25 healthy players. In doing this, he must be capable of making an accurate assessment of the length of disability in any illness or injury. This is dictated by the disability rules in baseball. If a player is ill or injured he cannot be replaced unless he is placed on the disability list for twenty-one days. During this period he cannot suit-up or occupy a seat in the dug-out. For lesser periods of disability the player may remain on the roster but his participation will obviously be limited. In most cases the decision is fairly simple but on occasion especially with musculoskeletal injuries it is difficult to precisely define the period of disability. The decision is further complicated by the numerous pressures to get a highly skilled regular player back in the line-up. Therefore, the team physician must resist these pressures and temptations and base his conclusions on the clinical findings and his experience with similar injuries or illnesses.

Summary

The team physician has an opportunity to work with a young, exceedingly talented, highly superstitious group of athletes. He must be constantly aware of the individual variations in motivation, response to injury and training habits of the players. He is often the only non-roster member of the team who is privy to the physical or emotional problems of the moment and as such must respect the confidence and have the trust of his patients. However, he is required to inform the management of serious problems and provide the news media with a valid reason for a player's absence from the line-up. This apparent paradox is best resolved by maintaining informal lines of communication with all the responsible individuals and limiting discussions to those health problems that relate to a player's ability to perform. ◀

Bankrupted Nation Cannot Be Great

"There is no such thing as a bankrupt great nation. There is no such thing as a flowering civilization in industry, in the arts, and sciences and humanities if it has swept away the savings of its people. One of the cruel ironies of our recent crisis is that much of the damage has been done in the name of the 'welfare state.' They called it the 'Great Society'—remember?"—Jenkin Lloyd Jones, president, Chamber of Commerce of the United States.

Successful Pregnancy

(Continued from page 81)

lesion characterized by almost total sclerosis of glomeruli and consistent with chronic diffuse glomerulonephritis. Renal function at the onset of pregnancy is unknown, but her subsequent course indicates that pregnancy almost certainly had an adverse effect on her disease. It is widely held that renal insufficiency constitutes adequate medical grounds for termination of pregnancy, and the fatal course of our patient certainly does not contradict this view. It should be borne in mind however that in rare instances, successful delivery of a normal infant is possible even in the face of severe renal damage and insufficiency.

Summary

A patient is reported who suffered from probable diffuse chronic glomerulonephritis and who gave birth to a normal infant at a time when she had severe uremia. Although the patient died from renal failure within a few weeks after delivery, this case illustrates that patients with severe uremia may in rare instances give birth to viable infants. ◀

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An illustrated lecture series entitled, "The Absorption and Malabsorption of Fat," is now available through the American Gastroenterological Association. The series features a core of four films on the intestinal absorbing surface, intraluminal fat digestion, the absorption and intracellular biotransformations of lipolytic products, and the enterohepatic circulation of bile acids. Write: National Medical Audiovisual Center, Station K, Atlanta, Georgia 30324.

Obituaries

***Ralph Baylin**, Chicago, died Nov. 9 at the age of 66. He was senior staff member of Belmont Community hospital.

Virginia Boshes, Chicago, died Dec. 7 at the age of 61. She was senior attending psychiatrist at Wesley Memorial Hospital and also associate professor of psychiatry at Northwestern University.

***Robert D. Bower**, Illiopolis, died October 31 at the age of 54. He was a member of the American Academy of General Practice.

***Earl R. Chamnes**, Carlinville, died July 6 at the age of 77. He was a past-president of the Macoupin County Medical Society and a member of the ISMS Fifty-Year Club.

***Urban V. Comes**, St. Petersburg, Fla., died Nov. 21 at the age of 80. He was a member of the ISMS Fifty-Year Club.

***Herbert B. Erikson**, Chicago, died Nov. 5 at the age of 70.

***Alfred B. Falk**, Skokie, died Nov. 23 at the age of 56. He was head of the dermatology department of Children's Memorial Hospital.

***George S. Frauenberger**, Evanston, died Nov. 28 at the age of 63.

***John J. Freeman**, Oak Park, died Nov. 23 at the age of 60.

***Samuel L. Gabby, Sr.**, Elgin, died Nov. 18 at the age of 89. He was past-president of the Kane County Medical Society and a member of the ISMS Fifty-Year Club.

***Joseph T. Gault**, Skokie, died Nov. 13 at the age of 69. He was professor of surgery at Chicago Medical School.

***Earl A. Kleinwachter**, Dolton, died July 18 at the age of 64.

***John M. Krupka**, Cicero, died Nov. 20 at the age of 65. He practiced in the Chicago area for more than 40 years.

***Randolph F. Olmsted**, Robinson, died Nov. 29 at the age of 70. He was past-president of the Crawford County Medical Society.

***George L. Rathbun**, Galesburg, died Aug. 29 at the age of 85. He was a member of the ISMS Fifty-Year Club.

***Dean F. Smiley**, Evanston, died Nov. 20 at the age of 75. He was secretary of the Association of American Medical colleges.

***Marion M. Taylor**, River Forest, died Nov. 9 at the age of 67.

***C. Martin Wood**, Decatur, died in October at the age of 94. He was past-president of the Macon County Medical Society and a member of the ISMS Fifty-Year Club.

*Indicates Member of Illinois State Medical Society.

The President's Page

Patient Responsibility

(Continued from page 10)

eous diagnoses and treatment suggestions that also delay the patient from seeking competent attention.

Other Emotional Disturbances

Besides fear, emotional disturbances of types too numerous to mention may lead the patient astray. Examples are anger, selfpity, unrequited love and apprehension. Emotional disturbances may delay the patient asking for help, may negate efforts to cure him or may even be the cause of his distress.

Cost

The much publicized cost of medical care undoubtedly causes some patients to hesitate seeking aid when they are ill. Most people either have sickness insurance or are covered by Medicare or Medicaid. The financial deterrent is most often noted in the refusal to cooperate by an inadequately insured, debt ridden person who requires essential but expensive procedures.

Physician Psychology

In order to encourage a patient's help the physician should explain to him the nature of his ailment and the logic of therapy. The sick patient is fearful that he may lose his life. He needs understanding, sympathy and re-assurance from his doctor. By displaying his interest and concern for his patient's welfare the physician can allay apprehension and earn the complete confidence of those under his care. The faith so engendered automatically assures the patient's willingness to aid in all ways possible.

Since patient cooperation as well as medical expertise is essential for good medical care let us hope our feature story writers and our government together with family and friends will aid the potential patient by advising faith in the doctor and early attention when he is ill. The busy physician should take time to assure the patient of his personal interests and concern, and that all necessary measures are being taken to speed recovery. He should explain the problem and the procedures. These measures will allay fear and insure cooperation through increased confidence.

J. Ernest Breed, M.D.
President-Elect

The Decision for a Medical Career

The decision to find one's career in medicine is the factor which ultimately determines the quality of our medical graduates, for the quality of the input must surely be the primary determinant of the output quality. The data compiled by the National Opinion Research Council, by Funkenstein, by Earley, and cited by Webster in his monograph, **Career Decisions and Professional Self-Images of Medical Students**, indicate many factors which modify or shape a premedical student's career decisions.

These studies indicate that medical career choices are made at an early age, and that the relative stability of such a career choice is high as compared with other career choices. Sixty per cent of medical students reported a firm career decision by the age of 18, and a study of career plans may be summarized as follows: many students relinquish medical career plans in the decade prior to high school graduation, 50% of college freshmen have changed to medicine since the eleventh grade and an equal number have changed to other career choices. By the senior year in college, about 50% of those freshmen aspiring to a medical career have changed to another choice, and these students are not replaced by others. (John Kirkland: Getting Into Medicine, **World Medical Journal**, [July-Aug.] 1969, page 80.)

It's the Will of the People That Counts

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New Pharmaceutical Specialties

(Continued from page 20)

Indications: Relief of nasal congestion, fever, aches, pains associated w/upper respiratory infections.

Contraindications: Individuals with high blood pressure, heart disease, diabetes or thyroid disease and children under 12 should use only as directed by physician.

Dosage: 2 tablets followed by 1 or 2 tablets/4 hrs. Do not exceed 8/24 hrs.

Supplied: Tablets.

HISTABID Inj. Cold Preparation

R

Manufacturer: Meyer

Composition: Each ml. contains:

Atropine sulfate	0.2 mg.
Chlorpheniramine Maleate	5.0 mg.
Phenylpropanolamine HCl	12.5 mg.
Chlorobutanol in water for inj.	0.5%

Indications: Symptomatic relief of upper respiratory tract infections and allergies.

Contraindications: Use with caution if at all in patients suffering from hypertension, hyperthyroidism, organic heart disease, severe diabetes mellitus, glaucoma or prostate hypertrophy.

Dosage: i.m. or s.c. 0.5-1 cc.

Supplied: Vials—10 cc.

VICON-C Vitamin Preparation

o-t-c

Manufacturer: Meyer

Composition: Each capsule contains:

Ascorbic Acid	300 mg.
Nicotinamide	100 mg.
Thiamine Mononitrate	20 mg.
d-Calcium Pantothenate	20 mg.
Riboflavin	10 mg.
Pyridoxine HCl	5 mg.
Magnesium Sulfate	50 mg.
Zinc Sulfate	50 mg.

Indications: Vitamin C, B-complex, zinc and/or magnesium deficiencies.

Contraindications: None mentioned.

Dosage: 1 tablet/day. In marked deficiencies—3/day with meals.

Supplied: Capsules

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R

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Nonproprietary Name: Sodium Ampicillin

Indications: Infections caused by sensitive strains of gram-negative and gram-positive bacteria in respiratory, genitourinary and gastrointestinal tracts.

Contraindications: History of allergic reactions to any of the penicillins and cephalosporins.

Dosage: i.m. or i.v.

Adults—250-500 mg./6 hrs.

Children—25-50 mg./kg./day at 6 hr. intervals.

Supplied: Vials—125, 250, 500 mg. and 1 gm.

DOCTOR! Does your coronary care team need a refresher? Send them to the Workshop on Coronary Care Units at the ISMS Annual Meeting—Wednesday, May 20, 1:30 P.M. Sherman House, Chicago.

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AAGP 40 CREDITS

Adrenal Neoplasm

(Continued from page 51)

tisone daily. ACTH is also given at varying intervals, initially three times a week, in an attempt to stimulate the atrophic contralateral adrenal cortex. Grant Liddle is able to demonstrate that during the first month after operation, endogenous production of ACTH is impaired, but later the pituitary gland again starts to produce ACTH. It takes from 6 to 9 months for the atrophic adrenal gland to respond to the endogenous production of ACTH. The normal pituitary-adrenal relationship including the feedback mechanism probably is not well established until about 1 year after operation. ◀

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(Continued from page 39)

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FLASH!

DOCTOR! Do you need a spirometer in your office? Attend the seminar on Management of Respiratory Insufficiency at the ISMS Annual Meeting—Wednesday, May 20, 1:30 P.M. Sherman House, Chicago.

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CLINICAL ARTICLES

Primary Hemangioma of the Pericardium <i>Victor R. Jablowski, M.D.</i>	144
Medical Aspects of Professional Basketball <i>David C. Bachman, M.D.</i>	149
The Other Side of the Coin <i>William Bauer, M.D.</i>	158
The Growth of Forensic Pathology in Illinois <i>Edwin F. Hirsch, M.D.</i>	188

SURGICAL GRAND ROUNDS

Hiatal Hernia after Vagotomy	139
------------------------------------	-----

SPECIAL ARTICLES

The University and Social Needs of the 70s <i>Alexander M. Schmidt, M.D.</i>	133
Maternal Mortality in Chicago <i>Stuart Abel, M.D., Jack Zackler, M.D.,</i> <i>Ronald Lechoky, M.D., and Hance C. Phillips, Jr., M.D.</i>	163

What "Generation Gap?"—1969 IMJ Membership Opinion Survey	168
---	-----

FEATURES

The President's Page	124
Editorials	138
The Doctor's Library	147
The View Box	156
Obituaries	157
Public Affairs Library	162
Clinics for Crippled Children	167
Membership Forum	174
Illinois Medical Assistants Association	178
Socio-Economic News	179
Meeting Memos	183
Physicians Placement Service	186
New Pharmaceutical Products	193

(Cover story on page 112)

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Vol. 4, No. 2

February, 1970



Medical Society Meetings Begin

Fred A. Tworoger, M.D., President of the Chicago Medical Society and John C. Troxel, M.D., Senior Vice President and Medical Director of the Blue Shield Plan of Illinois Medical Service discussed topics of mutual interest at the last Clinical Conference of the Chicago Medical Society.

This year, as in the past, Blue Shield will be exhibiting at Illinois medical conferences and conventions. The schedule will include:

1. Clinical Conference of the Chicago Medical Society—Sherman House, March 1, 2, 3, 4
2. Illinois Academy of General Practice Annual Meeting—Pheasant Run Lodge, April 13, 14, 15, 16
3. Illinois State Medical Society Annual Convention—Sherman House, May 17, 18, 19, 20

At all meetings, the booth will be staffed by Representatives of the Professional Relations Department who will answer your questions pertaining to Blue Shield and Medicare.

Expenditures and Costs For Health Care

Newspapers and some scholarly journals are replete with references to the cost of health care. An element of confusion, in the popular mind, and to some extent, in the technically trained mind is failure to recognize the difference between prices and expenditures.

If you purchase four shirts instead of one, you don't say that prices or costs of shirts have risen. Likewise, if your wife buys six pairs of shoes instead of three, you don't say the costs or prices of women's shoes have doubled when it is expenditures that have doubled. Neither is it appropriate to say that health care costs have risen because patients want four physician visits instead of two. In all three examples, larger sums of money are expended for greater quantities of goods and services. This does not mean that costs or prices have risen. Unless consumers have had to give up offsetting amounts, or more, of other goods and services, it means in a very significant sense that their standards of living have risen.

No one denies that a rise in health care costs has taken place but it is important not to call a rise in expenditures a rise in costs. Your patients, Blue Cross-Blue Shield members, and other members of the population must keep it clear in their minds that they may expect to spend more dollars when more services are consumed.

A cost, or price, does not refer to a quantity of goods or services but to a single unit of good or service. It is possible for expenditures to rise because of a rise in costs rather than quantity. It is also conceivable for expenditures to rise while costs decline. Expenditures can move in one direction while costs move in another.

During the past thirty or more years as consumption has increased from about 2.5 to 5.0 physician visits per person per year, expenditures for such services have also risen. However, an important shift has been from home to office visits where about 50% of all physician-patient visits occurred in each location in the 1930's. In more recent years, 90% of such visits occur in the Doctor's office. The shift has contributed to greater physician productivity and the increase in expenditures for a greater number of visits is smaller than it would have been if the ratio of home to office visits had not declined.

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Reimbursement for Hemodialysis Equipment

Medicare regulations allow your patient to be reimbursed for the rental or purchase of durable medical equipment if the equipment meets the following requirements:

1. it is customarily and primarily used to serve a medical purpose;
2. it can withstand repeated use;
3. it is generally not useful to a person in the absence of an illness or injury.

Durable equipment also must be necessary and reasonable for the treatment of a specific diagnosis and prescribed by you as the patient's physician. Also, the equipment must be used in your patient's home.

All Part "B" Medicare carriers have received a directive from the Social Security Administration indicating that hemodialysis equipment can be considered durable medical equipment when the above requirements are met.

Medicare will make reimbursement for two types of hemodialysis machines: the twin coil unit and the parallel flow unit.

Payment also may be made for repairs, maintenance and delivery as well as for expendable and nonuseable items necessary for the effective use of the equipment. However, no payment can be made for items such as blood pressure cuff, stethoscopes, forceps and scissors.

The decision to rent or purchase the equipment should be made by your patient. If your patient decides to purchase the equipment, monthly installment payments will be made either to your patient or to the supplier if he accepts an assignment. The monthly payments will be in amounts not to exceed the monthly rental charge.

Medicare also recognizes the possibility that a patient may need assistance in operating the equipment. Reimbursement can be made for training a lay person, such as a relative, to assist your patient when necessary.

Reimbursement on Laboratory Charges

According to Medicare regulations, reimbursement can be made for laboratory services but the following information is necessary:

1. the name of each test;
2. the charge for each test;
3. the diagnosis which necessitated the test(s).

This information is needed to determine the medical necessity of the test, and to determine the basis of payment.

Reimbursement for Injections

In order to prevent unnecessary delays for reimbursement of Medicare claims, particularly for office visits when injections are given, please provide the following information:

1. the charge for the office visit;
2. the charge for the injection;
3. the name of the injection;
4. the diagnosis.

Drugs and biologicals are covered by Medicare if they cannot be self-administered and if they are reasonable and necessary for the diagnosis or treatment of the illness or injury indicated on the Medicare "Request for Payment" form.

Vaccinations or inoculations are excluded as "immunizations" unless they are directly related to the treatment of an injury or direct exposure to a disease. Preventive immunization as well as prescribed and non-prescribed drugs and biologicals purchased by or dispensed to a patient are not covered.

The injected drug must be named and the charge for the injection and diagnosis must be reported on the Form SSA 1490, "Request for Payment" or attached itemized statements to insure prompt processing.

Who Performed the Service?

A Medicare claim, whether you do or do not accept an assignment, must indicate the name of the physician who personally provided the services. The SSA 1490 "Request for Payment" form can be pre-printed with the name and address of the physician who practices in the five county area of Cook, Kane, Lake, DuPage, and Will. Physicians in this area who do not use the pre-printed forms should indicate in item #8 of the SSA 1490 the full name and address of the physician who rendered the services listed.

Payments will be delayed when an itemized statement is submitted on letterhead listing more than one physician when the physician who provided the service is not identified. When this occurs, it will be necessary for our Representatives to contact you or your office assistant by telephone or letter to obtain the information in order to make payment.

Therefore, to prevent unnecessary delays in payment, please indicate the name of the physician who provided the service if the bill lists the names of more than one physician as well as supplying complete information on the SSA "Request for Payment" form 1490.

PLEASE HELP US

Lately we have received many inquiries from patients who were referred to the Professional Relations Department of Blue Shield by their doctors or their doctors' office assistants.

The Professional Relations Department was established to provide services to professionals and their office assistants and to handle inquiries referred directly to them by the medical profession. We would appreciate your telling your patients if they have questions to telephone either Medicare 661-4252 or Blue Cross-Blue Shield 661-4200 or to write to the Plan at 222 North Dearborn, Chicago, Illinois 60601.



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Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: Central Nervous System—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. **Autonomic Nervous System—**Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. **Endocrine System—**Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. **Skin—**Dermatitis and skin eruptions of the urticarial type, photosensitivity. **Cardiovascular System—**Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. **Other—**A single case described as parotid swelling.



SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384

Frustration and Disease

Frustration connected with confinement and the influence of this frustration on the development of arteriosclerosis, is being studied by a University of Chicago team of research investigators.

In a unique study on Rhesus monkeys, Dr. Robert W. Wissler, professor and chairman of the Department of Pathology, The University of Chicago's Pritzker School of Medicine, working with Dr. Dragoslava Vesselinovitch, research associate, and with other colleagues, has found that the standard confinement of laboratory animals in cages has little effect on the development of this disease that affects so many million Americans.

The researchers reported their findings after a 10-month study in which the development of both coronary artery disease and arteriosclerosis of other parts of the arterial system was studied. They used 10 pairs of monkeys which were comparable in weight, initial serum cholesterol values and which were fed equal quantities of a arteriosclerosis producing diet that they have been developing for a number of years.

The 10 animals confined in standard sized cages like those usually used in laboratory experiments were compared with 10 animals which were allowed 10 times

more freedom of movement including access to the outdoors. Neither the blood tests for lipid levels of the two groups nor the findings at autopsy indicated a substantial effect of the more confined caging. There was, however, a trend for the animals subjected to the more restricted caging conditions to develop somewhat more severe arteriosclerosis, especially in the coronary arteries. This occurred in spite of a slightly lower level of blood cholesterol in these traditionally caged animals.

Dr. Wissler commented, "These results indicate that the effect of living under conditions which might have their human counterpart in large cities does not constitute a major factor in the development of this widespread disease in man."

The lack of correlation observed in this experiment between the blood cholesterol values and the degree of coronary arteriosclerosis observed at autopsy is sometimes observed in man even though the usual observation is for these two aspects of disease to be directly related. According to Dr. Wissler, further study of this puzzling phenomenon may give new clues as to the mechanism by which severe coronary disease sometimes shows exceptional severity even when blood cholesterol values and dietary history would not lead one to expect severe disease.

ISMS Annual Convention May 17-20 Sherman House, Chicago

ON THE COVER

We call our readers' attention this month to the vast medical resources of the University of Illinois West Side Medical Center, Chicago. With today's rising concern over adequate medical care for the future, Illinois physicians can be proud that the University of Illinois, College of Medicine is already harnessing its resources to meet this on-going challenge. We direct your attention to the article entitled, "The University and the Social Needs of the 70's," by Alexander Schmidt, M.D., executive associate dean, University of Illinois, College of Medicine, found on page 133 for a more penetrating look at how one great university is attempting to solve the health care problems of the coming decade.



Edward W. Cannady, M.D.

The President's Page

Kidnapped

Thousands of our young people are being kidnapped each year, while parents and community stand by helplessly. The kidnapper is drug abuse, and our children and teenagers are unwittingly following it on dead-end "trips" to nowhere.

As parents ourselves, we share the concern of all parents about the drug abuse. And as physicians, we hold a special responsibility to help the community rid itself of this menace.

Within the past year, many communities have launched local campaigns to combat drug misuse, particularly among junior high and high school age youngsters. Some communities have become so alarmed that citizen's groups have advocated such measures as blood and urine tests in high schools to screen out drug users. A more thoughtful approach to the problem is "Operation Drug Alert," an education and prevention program sponsored by local Kiwanis Clubs.

As more and more communities undertake anti-drug abuse campaigns, we physicians will be called upon for information, advice and leadership. Last year, for example, I spoke at the St. Charles and Champaign Kiwanis clubs to kick off their "Drug Alert" programs.

In talking with adults, I have found there is an amazing amount of misunderstanding and misinformation about drug abuse. In

many cases, youngsters know more than their parents.

Thus physicians should help adults—as well as young people—become better informed about the dangers of drug use. We should discourage approaches to the drug abuse problem which are built upon little knowledge and much emotion. When appropriate, we should accept positions of leadership in local drug abuse efforts.

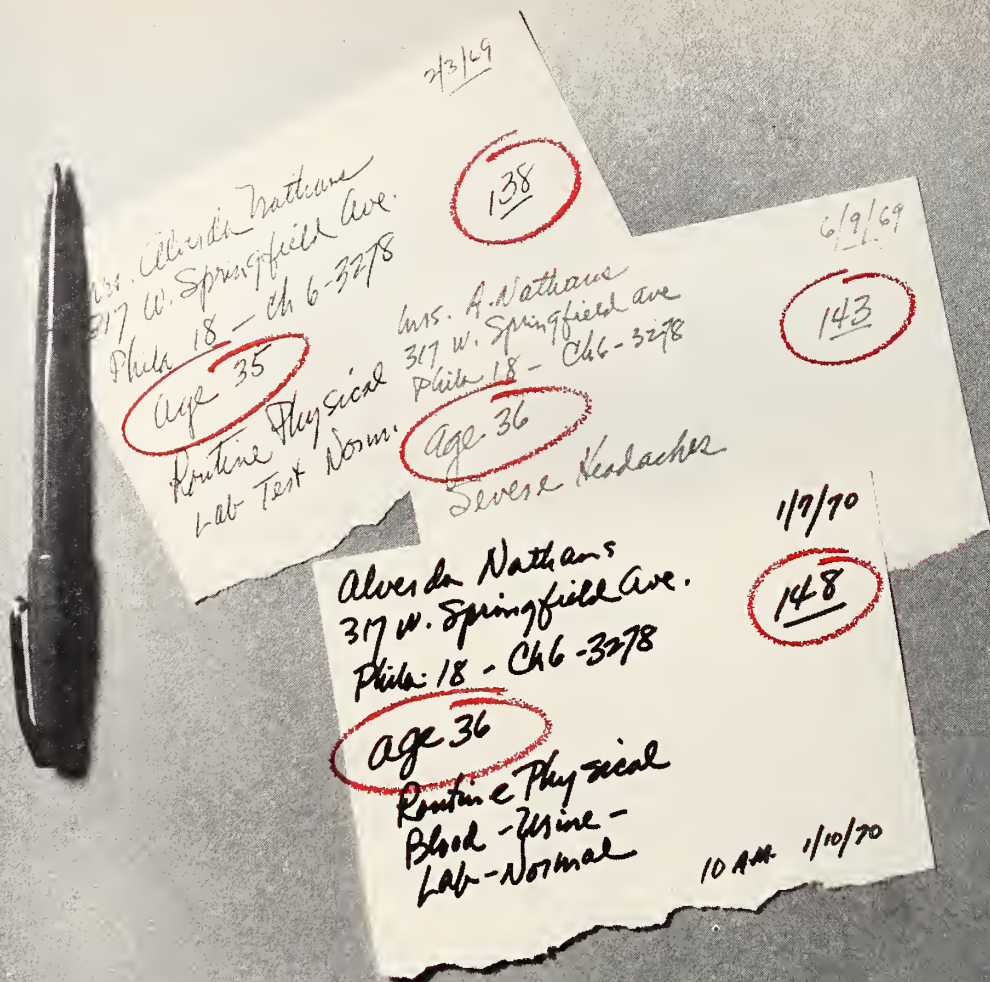
Obviously we ourselves must be well acquainted with the drug abuse menace particularly in our own community. A brief discussion with a school nurse or high school counselor can be very enlightening. Your community drug problem may be a good deal more serious than you suspect.

As for background information on drugs and drug use, many excellent materials are in the Drug Abuse Information Kit available from the AMA. The AMA's new booklet "Drug Dependence . . . A Guide for Physicians," may also be helpful.

Perhaps your county medical society may wish to initiate or cooperate in a drug education program in your area. Here is an opportunity to put the power of preventive medicine to work.

Edward W. Cannady

ISMS Annual Convention May 17-20
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The University & Social Needs of the 70's

BY ALEXANDER M. SCHMIDT, M.D./RIVER FOREST

In our speeded-up world, hopes become expectations (and expectations in turn become demands) very quickly. Present student expectations go beyond the traditional academic programs to encompass numerous social issues to which, it is thought, universities should be responsive. I agree that there is a proper university response to at least some social needs. I will discuss those needs and how universities and their colleges of medicine, and the University of Illinois College of Medicine in particular, can be responsive and relevant to the coming decade of crises, challenge, uncertainty, and growing societal needs.

Alexander M. Schmidt, M.D., is executive associate dean, University of Illinois, College of Medicine. A former chief, Education and Training, Division of Regional Medical Programs, Dept. of HEW, he received his M.D. degree from the University of Utah.



It should first be said that the coming decade will present some of the most difficult and perhaps cataclysmic problems faced by a relatively unprepared mankind since the great plagues of the middle ages. We are as lacking in understanding at this point in time of the causes of some of our problems, and are as devoid of possible solutions, as were our unfortunate ancestors seeking to explain and control the plague. In the coming decade we will face crises caused by our current inability to deal with such matters as our growing population, the depletion of our resources, the rational use of atomic power and of space, and the wise and humane use of the tremendous capabilities of our machines. "We are in the presence, perhaps, of a turning-point in human affairs so immense that we do not perceive it."¹ The immensity of our circumstances is difficult for us to perceive, inured as we are to large numbers—the millions in our cities, the billions of our defense budget and of the national debt. We lose perspective on issues such as I enumerated. Let me illustrate, using our popu-



Shown above is the University of Illinois Hospital—the educational, research and service center of the Medical Center Campus for students in the Colleges of Medicine, Dentistry, Pharmacy and Nursing, the Graduate College and the School of Associated Medical Sciences.

lation growth as the example. It took from the beginning of recorded time to less than 150 years ago for the human population to reach 1 billion in number. It is now 3.5 billion, and will double by the year 2000. Most experts believe the population will level out at somewhere between 15 to 25 billion.² Gale Young of the Oak Ridge National Laboratories puts this into perspective by pointing out that on "this day there are born in the world 325,000 babies. During this 24 hours, 135,000 persons will die, 12,000 of them from hunger. The net increase is 190,000—enough to populate another New York City every 40 days. . . . Man gazes now at perhaps his final sunset; he confronts now perhaps his final mammoth—himself, and is senseless to the danger."² At least most of us are; we have not got the message yet.

Some have; I think this is made apparent by the revolts of today's youth. It is interesting to speculate as to why, among all our institutions, universities seem to be bearing the brunt of the disaffection of young people. One obvious answer is that so many of the young are in universities, so they are handy. Another is that the major purpose of the University is to encourage the questioning and challenge of our "established norms." But the degree of student unrest exceeds reasonable expectations based on these explanations, and must be attributed to the deep anger and frus-

tration of students disenchanted with our universities and the apparent inadequacy of university response to social need as measured against student expectations. Our young are not too sure of the virtues of our present society or of our chances of surviving to preserve what is good. Students have expected to find in universities faculties, curricula and programs that are responsive and relevant to what are considered to be the main issues. Instead, we are told, they discover an impersonal atmosphere in which specialists pursue their own narrow interests, curricula which are tailored to the needs of the faculty, and research programs seemingly directed as much to the destruction as to the preservation of mankind. They say they find what Nietzsche called the "advancement of learning at the expense of man."

Another aspect of this view is seen by those arguing that it is to the universities that society must now turn for solutions to the immense problems of today. Universities are society's most important means of establishing truth, and our future must depend on what we know to be true. Realizing these things, most universities are now examining and in some cases redefining their roles in fulfilling educational needs of students and responding to the practical needs of society. I believe this is a beneficial result of recent campus unrest, which in and of itself has often seemed so destructive.

John Gardner paraphrased Alfred North Whitehead by saying, "Celibacy does not suit a university." But neither does promiscuity. Samuel Gould, the Chancellor of the State University of New York at Albany, sought the balance by stating, "There is a danger in the steady parade of requests for service to a university—that of a proliferation of activities that throw the university's total mission seriously out of balance."³ The academic life can become academic in name only, if programs of community service, worthy in and of themselves, begin to outweigh the most fundamental function of a university—education and the search for truth. Richard Weinerman of Yale University's School of Medicine writes, "The essence of the challenge to the academic medical community is the present imbalance between its technical excellence on the one hand, and its growing

irrelevance, on the other, to the needs of society which supports it. . . . One cannot argue for large scale service involvement of institutions which society holds responsible for preparing expert physicians and for advancing the frontiers of medical knowledge."⁴ This quote hints at the discussions now ongoing in our academic medical institutions, which, like their parent universities, are engaged in a process of redefining goals, of examining internal processes, and seeking better ways to meet the requirements of the informed, thinking, articulate and involved students entering its halls.

Through such assessments, several conclusions have been drawn with enough clarity for them to serve as guides for our medical faculties formulating future programs. The first is that no matter what occurs in our medical care system or in the development of new types of health manpower, we will need many more physicians in the very near future than we are capable of supplying. Secondly, no matter how many physicians we do supply, their future activities, if similar in nature to those of present day physicians, will not provide the amount and kind of service society will need in 1975, not to mention in 1984. Thirdly, we simply do not at this time know enough about our present health care system to be able to make necessary judgments concerning how best either to alter it or to train health workers to enter it. The definition of needed changes in our health care system and in our health educational system will depend on systematic and rational study of the systems we now have, and sound experimentation with alternatives possible for the future.

About all we now know for certain is that in 1968, 9,473 physicians were produced by our colleges of medicine. In 1969, 9,730 were graduated, and counting all new and projected medical schools, we will be able to graduate between 12 and 13,000 by 1973. These students will be drawn from a qualified pool of 25 to 26,000 applicants. Were we able to graduate them all, we still would not satisfy the projected national need for physicians.

The program planned for the University of Illinois College of Medicine is to accomplish two main purposes: to increase the numbers of physicians available to this state, and to foster innovation and experi-

mentation in our education, research, and service programs, while yet maintaining the traditional academic posture so vital to the proper function and excellence of a university.

The University of Illinois College of Medicine is large already, and this past fall admitted 20 additional students, a 10% increase, bringing the total number of entering students to 225. The University has thus already accepted the challenge to enlarge; but in addition, it is formulating plans that will lead to 400 students entering each year by 1976 or 1977. This is essentially twice the 205 students entering in 1968.

In thinking about the utility of large size and the economies of scale thus allowable, the College has considered the advantages to be gained by marshalling the considerable resources of the University of Illinois in support of a coordinated, efficient and relatively easily managed single effort, thus avoiding the necessarily larger expense in time, dollars, and faculty incurred by the establishment of additional medical colleges *de novo*. It now takes between 10 and 15 years, and costs upwards of 50 million dollars to establish a new medical college. Costs are now increasing at a rate of 1/2 to 1 million dollars a month. Against these discouraging figures one can consider the relative merit of expanding an ongoing program situated in the midst of one of the world's largest collections of medical facilities, Chicago's West Side Medical Center, containing some 7,000 hospital beds.

But there are obvious needs for medical educational programs throughout the state—programs in continuing education, postgraduate education in the form of internship and residency programs, and undergraduate medical education. These are needed by communities, in order to improve their total medical programs and recruit needed physicians, and by the University, in order to provide the desired breadth of educational experience for its students. Again, our premise is that these can most quickly and efficiently be established through efforts coordinated with, supported by, and in some cases integrated with the existing activities of the College of Medicine.

It is likely that the economies of scale

thus achieved would not be worth the disadvantages of the tremendous size resulting from a doubling of the present College of Medicine. Imagine 1,600 undergraduate students, an equal number of other students and house officers, hundreds of faculty, all within one administrative structure. There is genuine concern that such size would lead to further depersonalization and dehumanization of the educational process and might destroy the atmosphere necessary for intellectual achievement.

It is generally agreed that large size and excellence of an academic institution are not mutually exclusive; indeed, there is evidence that they are mutually supportive. Yet, there can be legitimate concern that in medical education, one should strive for an atmosphere and setting in which small numbers of faculty and students can work together in a clinical setting at learning about and solving the variety of health and health-care problems besetting our society today. It can be anticipated that a scholarly atmosphere in a medical institution can better be achieved with a student body of 100 to 150 than one of 400. Thus, we plan to return to educational units of smaller size than our present 225 students.

Another basic tenet of our planning is the provision of the opportunity not only for greater numbers of students, but for a greater variety of students to have access to a medical education. The current by-word is "flexibility," connoting the accommodation of different types of students—those with differing social backgrounds, differing academic preparation, differing rates of achievement, and differing career goals. The last recognizes the great diversity of career opportunities offered physicians, including family or a more limited specialty practice, teaching, research, preventive medicine, administration, etc. This variety of career choices, even in the absence of other factors, requires a flexible educational program. Flexibility in curriculum planning is desirable for a number of other reasons. We should be able to allow students to progress at their own best rate, and to avoid the duplication and repetition inherent in the more rigid lock-step curriculum. Most importantly, we must encourage students to become independent learners and scholars, imbued with

the ability and desire to educate themselves throughout their professional lives. This goal obviously requires a curriculum flexible to the point of individuality in study programs.

The Illinois Plan is intended to be responsive to all these needs, and one other—the need to identify those parts of the basic science curriculum that can and should be totally integrated with clinical studies, and then to design a truly integrated clinical curriculum. This also requires the identification of that basic science now taught that is truly prerequisite to the study of medicine. We believe it imperative to retain medicine's relation to basic science as well as the identity of the scientific disciplines basic to the art and practice of medicine. Some new schools have no basic science departments as such. Older schools are experimenting, to date largely unsuccessfully, with various rearrangements of curriculum time and faculty mix.

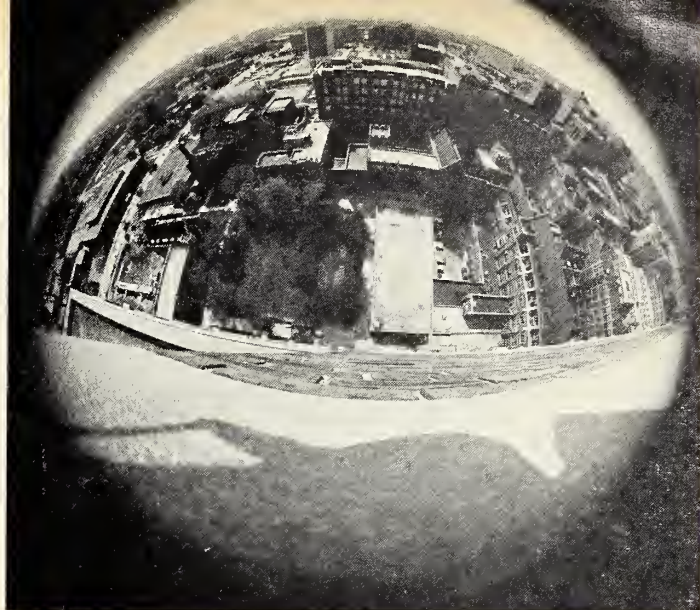
The University of Illinois Plan calls for the reorganization of the College of Medicine into a series of schools, each autonomous to develop its own organizational structure and educational programs to the degree consistent with the need for the faculty, acting through a residual College administrative structure, to foster academic excellence. Thus, the College of Medicine will oversee and support the establishment and maintenance of a series of semi-autonomous schools, each with its own faculty, student body, and educational research, and service programs. The schools will be two types—there will be one or two Schools of Basic Medical Science, and initially one, but relatively soon, three Schools of Clinical Medicine.

Students will typically enter first a School of Basic Medical Science, which will provide its students with the knowledge and understanding prerequisite to their entrance into a clinical school. Students will be examined for competency in basic sciences prior to entrance, and those with adequate preparation in their undergraduate work may omit part or all of the proposed one year basic science curriculum, either taking elective courses to advance their degree of mastery of a basic science, or else proceeding directly to a clinical school. Other students, having an inadequate preparation in basic sciences either

because of previous study of unrelated disciplines, or because of inadequate academic preparation in science, may require more than one year to prepare for their clinical studies. It is to be emphasized that elective courses in basic sciences will be available to all students at any time in their careers, should they want to or need to study a basic discipline in depth; also, it is anticipated that much basic science will be integrated into the clinical curricula, as was mentioned. It should be clear that this plan is not in any way to de-emphasize science—on the contrary, it is an attempt to strengthen its position in regard to the clinical disciplines.

Students will be matched with a clinical school, and will then enter their clinical school usually at the beginning of their second year. Those entering directly from undergraduate college will obviously have saved one year of time. The clinical schools will have a three year curriculum. Class size will range from 75 to 150 students depending on the school. We are planning to have four clinical schools by 1975—two in Chicago, and one each in Peoria and Rockford, Illinois. In future years, as the need grows and the resources become available, the College can then grow by the addition of more schools, preserving the advantage of moderate size of component units.

The schools in Peoria and in Rockford are to be established through the sequential establishment of first programs of continuing medical education, then postgraduate education, and finally undergraduate medical education. Each city has established Community Planning Boards, which are working with faculty of the College to plan the first steps of the above sequence. We plan to move ahead quickly with the selection of program directors and faculty. This is a most exciting part of the Illinois Plan, for these communities are demonstrating an ability and capacity to mount educational programs badly needed in the years ahead. Both have displayed interest in the establishment of family practice programs at the internship and residency levels, and are ideally suited to carry out these programs. But this is one of the attractive features of the plan—it will allow a natural diversity of University programs, that viewed as segments might appear to relate closely to the needs, interests, and abilities of the local faculty



A "fish-eye" view of the west portion of the University of Illinois Medical Campus shown from atop the University of Illinois Hospital, 840 S. Wood Street. Along the right is the College of Medicine, flanked in the center by the eight-story Medical Sciences Addition.

and students, but taken as a whole will obviously represent a much enriched and more inclusive response of the University of Illinois to the needs of this state for increased numbers of a variety of well educated health professionals.

In giving an overview of our plan, I run the risk of important omissions. I have not mentioned our School of Associated Medical Sciences, which will be working hand in hand with the clinical schools in the development of new types of health professionals. I have not spoken much of the potential enrichment of research programs offered by the schools-within-the-College concept. For example, as schools develop their own distinctive and diverse programs, the total research effort of the College can include investigative efforts into patterns of health service in both rural and urban settings. The return to smaller classes hopefully can reintroduce students and faculty, who together can turn to learning the ultimate truths of science and humanity—perhaps our highest purpose. Finally, we can systematically study the changes we are implementing, and thus know to what extent we are achieving our goal of finding new and better ways for large colleges of medicine to function.

In this way, we hope to respond in what we consider our most appropriate manner to the immense needs of society in the next decade. ◀

(Continued on page 194)

EDITORIALS



TESTING FOR HEALTH

Multiphasic Screening Program

Multiphasic health checkup is now applied to a periodic health examination in which the physician uses an automated multiphasic screening program to obtain a comprehensive battery of laboratory tests for his patient. Mechanized and semi-automated equipment is utilized to determine, automatically, whether there is a likelihood that a disease is present to warrant further diagnostic tests. In essence, the physician is using an automatic multiphasic screening program prior to his own examination in order to save time without sacrificing thoroughness. Not only does this type of examination provide more information on a greater number of patients, but it provides more complete information on each patient.

Most physicians do not care where the patient has the tests done, so long as they are performed accurately, promptly, and at a reasonable cost. Automated equipment is accurate and economical because four or five times as many tests can be done for the same cost. Two multiphasic laboratories are now operating 40 hours weekly, each examines about 500 patients a week. The cost per screening was \$21.32. This includes

16 procedures and a physician interpretation of electrocardiograms, X-ray films, and retinal photographs. It does not cover charges for the physical done by the physician after he receives the data.

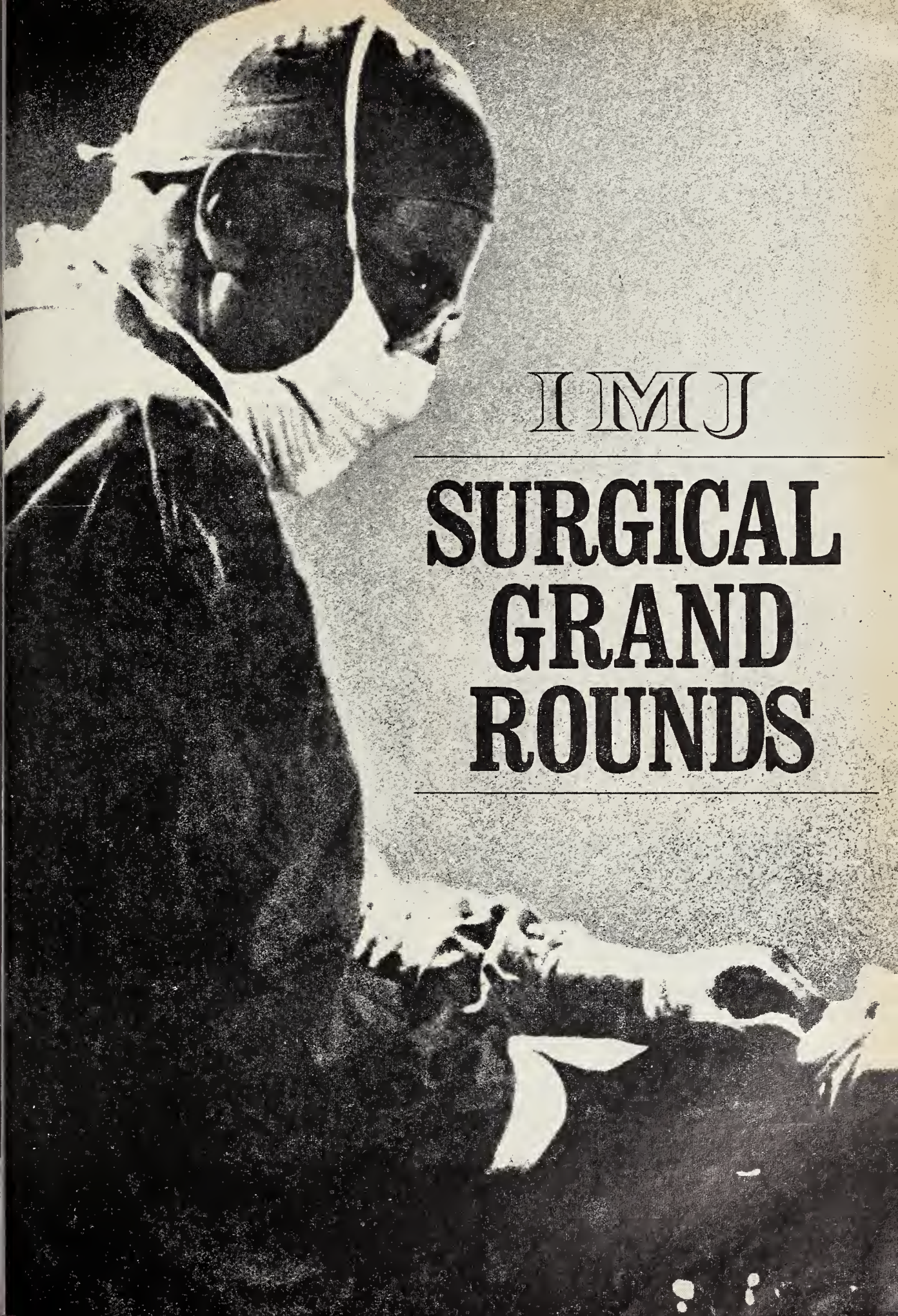
According to "Medical News Report," multiphasic health testing is fast becoming popular. Firms going into this field include Medisystems, Inc., Medidata Sciences, Inc., Mediquip, Inc., Pelam, Inc., Medi-screen, and Health Evaluation Systems, Inc. When health insurance companies and prepayment plans include preventive-type examinations in their plans, multiphasic health testing will boom.

According to Collen¹ "It is reasonable to project that once automated multiphasic screening programs become generally available, the practicing physician will not only readily accept and adjust to them but will soon consider these services as indispensable for his patients."

T. R. Van Dellen, M.D.

Reference

1. Collen, Morris, F., "Value of Multiphasic Health Checkups," *New England J. of Med.*, 280:1072 (May 8) 1969.



IMJ

SURGICAL GRAND ROUNDS

Hiatal Hernia

After Vagotomy

EDITED BY JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at the Veterans Administration Research Hospital on July 12, 1969.



Fig. 1. Duodenal ulcer was demonstrated by upper gastrointestinal X-ray study before first operation.

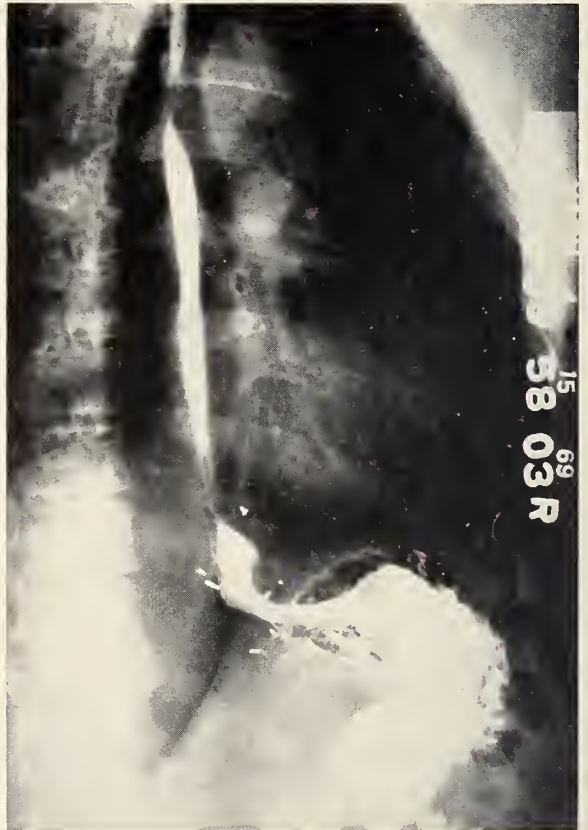


Fig. 2. Hiatus hernia was demonstrated after vagotomy and pyloroplasty.

Case Report

Dr. Sidney P. Haid: A 55-year-old white man was admitted to the Veterans Administration Research Hospital in December 1968 for surgical treatment of a duodenal ulcer. He gave a history of peptic ulcer symptoms of 10 years duration with two episodes of bleeding. Medical management had failed to control his ulcer symptoms. On December 18 vagotomy and pyloroplasty were performed. His immediate postoperative course was uncomplicated and he recovered from the operation well. However, in January 1969, he began to complain of retrosternal, burning pain following meals, which was related to position. If he laid down or bent forward it became quite worse. He was followed in the outpatient clinic. The use of antacids and remaining erect after meals did not relieve the pain. An upper gastrointestinal X-ray study was performed in April 1969.

Dr. Michael Murphy: An upper gastrointestinal series was done before the first surgical procedure and showed a markedly deformed duodenal bulb. (Fig. 1) Other films showed a persistent outpouching of the bulb thought to represent an active ulcer crater. Repeat upper gastrointestinal study done after vagotomy showed a widely patent gastric outlet that emptied well without evidence of obstruction. Metal clips placed on the vagus subdiaphragmatically were now located well above the level of the diaphragm and surrounded a small hiatus hernia. (Fig. 2) Chest film taken after repair of the hiatus hernia showed that the metal clips were located below the diaphragm indicating reduction of the hiatus hernia. (Fig. 3)

Dr. Haid: Difficulty had been encountered at the time of the operation. Excessive bleeding had occurred when the triangular ligament of the left lobe of the liver was divided, and the esophagus had been entered when the vagus nerves were isolated. He was readmitted to the hospital in May 1969. A 12-hour overnight collection of gastric secretion yielded a volume of 1,450 cc and free acid of 6.3 mEq/L. Esophagoscopy was performed and the findings were compatible with those of peptic esophagitis. A biopsy was taken and showed chronic esophagitis. An acid perfusion test was done and was thought to be negative.



Fig. 3. After repair of the hiatus hernia, the metal clips were shown to lie below the diaphragm.

Pulmonary function tests were performed and were within normal limits. On June 20, a hiatus hernia repair was performed.

PATIENT ENTERS

Dr. Thomas W. Shields: You developed burning discomfort in your chest after the first operation. Had you ever had this symptom prior to the operation last Fall?

Patient: No. After the first operation, I always had a burning feeling, particularly when I laid down.

Dr. Shields: How have you felt since the second operation?

Patient: The burning is gone and I feel much better.

Dr. Shields: Did you have any other difficulty after the last operation?

Patient: I had some trouble eating for awhile. It seemed as though I couldn't get the food down. Sometimes I would get hiccoughs.

Dr. Shields: How long did this last?

Patient: For about a week, but now it is gone.

PATIENT LEAVES

Dr. Shields: Postoperatively there was temporary partial obstruction in the esophageal outlet and he had typical symptoms of some discomfort, difficulty in swallowing and hiccoughs. With time this has subsided. This is one of the potential difficulties that is encountered with the particular repair which we used in this patient.

Before Dr. Haid discusses the problem

of hiatus hernia following vagotomy, a few remarks are appropriate. The initial operation was complicated by hemorrhage from a large vein when the triangular ligament of the left lobe of the liver was divided. I was not present, but it is apparent that there was some difficulty in controlling the bleeding. Three units of blood were used during the procedure. Later, in mobilizing the esophagus there was an inadvertent perforation of the esophagus which was recognized and closed. There was no attempt at repair of the phreno esophageal ligament at the completion of the vagotomy.

Dr. Haid: Vagotomy is associated with surprisingly few serious complications. When postoperative complications do occur, many are the result of an error in technique. Among the complications that have been reported after vagotomy are esophageal perforation, devascularization of the esophagus, pneumo thorax, hemorrhage, dysphagia, which may be on a neurogenic basis due to edema or hematoma formation around the esophagus, and hiatal hernia. The first report of hiatus hernia following vagotomy was by Beal in 1948.¹ He had a 37-year-old patient who had a vagotomy alone. Symptomatology of a hiatus hernia occurred within 10 days of surgery and was confirmed by radiologic study. Hiatus herniorrhaphy was performed at a later date. Sporadic reports of this phenomenon have appeared. The largest series was reported recently by Posthelthwait and his associates who studied 135 consecutive patients following vagotomy and found X-ray evidence of hiatal hernia in 15.² Although this is an incidence of 11%, none of the patients had symptoms attributable to their hiatus hernia. Clark and his associates³ studied 32 cases. Before vagotomy intermittent reflux was present in nine. After operation, 11 had symptoms of reflux and in six of these there was an increase in severity from the preoperative state. One hiatus hernia was demonstrated. Tolstedt and Bell⁴ who described two cases suggested that perhaps this is more common than we realize but because in most cases there is decreased acid content in the stomach the patients are not symptomatic and therefore are not studied postoperatively. They recommended that if unsuspected hiatal hernia is found when vagotomy and pyloroplasty are to be performed

that the hiatal hernia should be repaired at the same time.

Most authors agree that the cause of this unusual sequella is a patulous esophageal hiatus on an iatrogenic basis. The best means of prevention is repair of the hiatus at the time of operation. In one of Dragstedt's early articles in 1947 he suggested, "When satisfied that vagotomy is complete and that hemostasis has been secured the operator closes the opening into the mediastinum with three or four catgut sutures."⁵ Beal agreed with this but preferred silk as a suture material. In most cases, it would seem appropriate to suture the phrenoesophageal ligament to its attachment adjacent to the gastroesophageal junction. If a hiatus hernia was not present before operation, this relatively simple maneuver should be adequate and sufficient to prevent the development of this relatively uncommon complication.

Dr. Shields: This is the first patient that we've encountered at the Veterans Administration Research Hospital with this particular complication. The stage was set in this patient because of multiple complications at the initial operation. There was more trauma to the hiatus than is normally encountered, and as pointed out, failure to reconstitute the hiatus and the phrenoesophageal ligament occurred. Though the herniation of the cardia into the chest was quite small, loss of the normal sphincter mechanism occurred and the patient developed a severe esophagitis from regurgitation of gastric juices into the lower esophagus.

Because of the serious technical problem at the first operation and the very strong possibility of dense adhesions intra-abdominally, a transthoracic repair of the hernia was elected as the procedure of choice. It was also reasoned that more than a standard repair of the hernia would be necessary to insure the prevention of reflux from the stomach into the esophagus postoperatively. The repair that was thought most likely to accomplish this was the Belsey⁷ modification of the Allison⁸ repair. In this procedure, in addition to the repair of the hiatus itself, the esophagus is inverted into the cardia of stomach to form a valve which would effectively prevent postoperative regurgitation. Dr. Belsey, an English surgeon, has performed this procedure in over 600 patients with

reported good results in 85% of the patients. Recurrence has occurred in 7% and an additional 4% have had a poor result but with no demonstration of a recurrence. A mortality of 1% was experienced. Paulson,⁶ in this country, has utilized a slightly modified Belsey procedure in a little more than 200 patients and his results are quite similar to those reported by Belsey.

In the patient under discussion we followed essentially the technic described by Paulson. After freeing the esophagus and cardia and preparing the hiatus for closure postoperatively, the esophagus was invaginated into the cardia by two rows of interrupted #2-0 silk sutures. The first row, of six sutures extending approximately 240° around the circumference of the esophagus from the right to the left vagus nerve was placed from the stomach to the phrenoesophageal ligament and esophageal wall as mattress sutures and tied. The second row was then placed as mattress sutures into the diaphragmatic rim, then carried to the stomach one centimeter distal to the first row of sutures and then carried one centimeter above on the esophageal wall and again tied, further invaginating the esophagus into the stomach and bringing the diaphragm about the esophagus.

The crus was then approximated posteriorly by tying the previously placed sutures in order to complete the repair.

The patient's operative and postoperative course were uneventful except for the above noted temporary difficulty with swallowing. The initial result has been excellent with complete disappearance of the patient's symptoms and we anticipate complete healing of the preoperative esophagitis. ◀

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HEART ASSOCIATION RECONFIRMS ADVICE

The American Heart Association has affirmed its earlier advice that the American people control the amounts of saturated fats and cholesterol in their diets if they hope to reduce the toll of heart attacks, which now claim more than 570,000 lives a year.

Taking into account supporting scientific data accumulated over the past three years, the Association has issued a new statement on Diet and Heart Disease which states that there "is evidence that the risk of developing premature coronary heart disease can be reduced if prolonged high levels of cholesterol in the blood are avoided." The statement also made these points:

Accurate labeling of vegetable oil products would help consumers identify those

brands most effective in lowering cholesterol levels.

There is urgent need for a nationwide study involving large numbers of healthy people to provide an unequivocal answer to whether lowering cholesterol levels can reduce heart attacks. Much of current data on diet and heart disease is from studies of subjects atypical of the general population.

For the time being, the Heart Association has recommended specific changes in the typical American diet aimed at lowering the risk of heart attack. It said coronary heart disease is the result of many risk factors, and indicated that a diet rich in saturated fats and cholesterol is one important risk factor that can safely be modified.

Primary Hemangioma of the Pericardium

BY VICTOR R. JABLOKOW, M.D./HINES

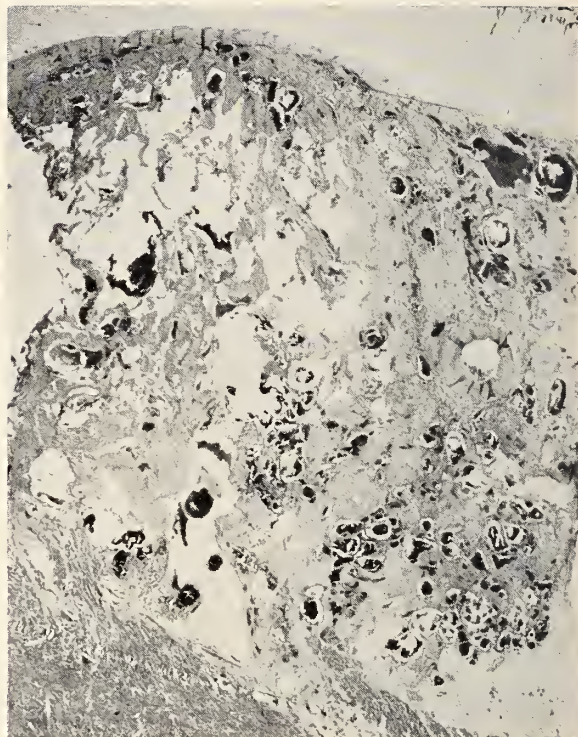


Fig. 1. Low power view of the epicardium with cavernous hemangioma. Hemotoxylin and eosin.

Angiomatous tumors of the pericardium are rare, and only isolated case reports have appeared in the literature.

Hicken, et al,² in 1963 reviewed the literature and found 12 acceptable cases of hemangiomas involving pericardium. They described a case of angiomatosis involving pericardium in a 36-year-old male who developed spontaneous hemopericardium. Both visceral and parietal pericardium had multiple separate angiomatous proliferations.

Kleinschmidt⁴ in 1964 reported a case of cavernous hemangioma involving epicardium found at autopsy in a 63-year-old man. It measured 3.5 x 2 x 2 cm. and was located at the base of the left atrium.

Following is a case of hemangioma involving the epicardial surface of the heart found at autopsy.

Case Report

A 64-year-old Negro male was admitted to Hines Veterans Administration Hospital in May, 1960, because of cystitis and urinary incontinence. He had had numerous previous admissions from 1934 to 1960 because of diabetes and arteriosclerotic heart disease.

In 1945, he had amputations of the left leg above the knee and right foot because of arteriosclerosis obliterans. He also had had a right lumbar sympathectomy. In 1920 the patient was treated for syphilis.

Physical examination on admission revealed a well-developed, poorly nourished patient who appeared to be chronically ill. Pulse was 110 beats/min., blood pressure 184/124 mm. Hg. Temperature was normal. The heart showed normal sinus rhythm and was somewhat enlarged. The lungs revealed basal rales. The prostate

was enlarged but not tender. The rest of the examination was not contributory.

Laboratory data: Non protein nitrogen 52.5 mg./100 ml., serology, non-reactive. Urine analysis revealed four plus albumin, 3 to 5 red blood cells per high power field, and specific gravity of 1.010. No glucosuria. White blood cell count was 19,900/cu. mm., hemoglobin 14 gm/100 ml. of blood, hematocrit 40, alkaline phosphatase 5.0 K-A units, acid phosphatase 3.6, blood sugar 105 mg/100 ml., CO₂ 19.9, serum sodium 130 mEq/L, chlorides 95.0 mg./100 ml., A roentgenogram of the chest revealed cardiomegaly and arteriosclerotic changes of the aorta.

Attempts to correct congestive heart failure and uremia failed, and the patient expired.

The pertinent autopsy findings were confined to the heart. The weight of the heart was 480 grams. There was evidence of fibrinous (uremic) pericarditis. The pericardial cavity contained approximately 15 cc. of yellowish fluid.

The epicardial surface revealed a bluish soft mass located between the origin of the pulmonary artery at the conus arteriosus and right auricular appendage close to coronary sulcus. The lesion measured approximately 3 x 2.5 cm. and had a thickness of 1.2 cm. It was covered with smooth, epicardial surface.

Sectioning revealed a spongy red appearance. The lesion was well circumscribed. No connection to the coronary artery branches was demonstrated.

The microscopic sections of the epicardial lesion revealed cavernous dilatation of the endothelium-lined spaces filled with red blood cells (Fig. 1). The angiomatic spaces close to the myocardial muscle in some areas appeared to extend into the

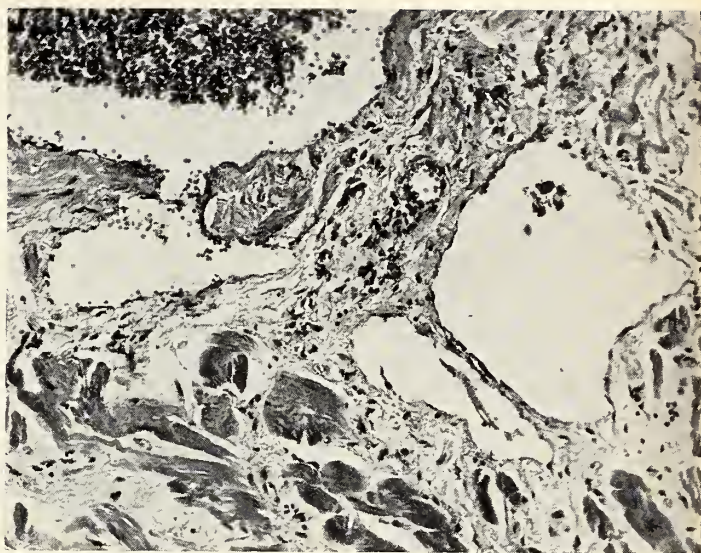


Fig. 2. Angiomatic spaces extending into the myocardium. Hematoxylin and eosin X 100.

myocardium for a small distance (Fig. 2). Many of the spaces contained a large amount of blood, but some were empty. The spaces were lined with flat endothelial cells. The stroma in most instances was thick and consisted of fibrous tissue. In some of the areas the stroma was very delicate and thin, and only very thin endothelium-lined membrane separated the adjoining cavernous cavities or spaces (Fig. 3). The cavernous spaces had different sizes. Few focal lymphocytic infiltrates and a few histiocytes were present in the stroma. The lesion was not encapsulated. It included several thick-walled blood vessels which were located in the middle of the specimen and probably represented branches of coronary artery passing through. The overlying epicardial layer was thickened. No capillary proliferations were seen. No mitoses were present. No thrombi were found. The interstitial tissue contained collagen fibers and smooth muscle. No angiomatic lesions were present in other organs.

Comments

Although hemangiomas are common lesions in other parts of the body, they involve pericardium only infrequently. They may attain large size. For instance, Link,⁵ reported one measuring 13.5 x 11.8 cm. Other cases ranged from 1 x 0.5 (Green-

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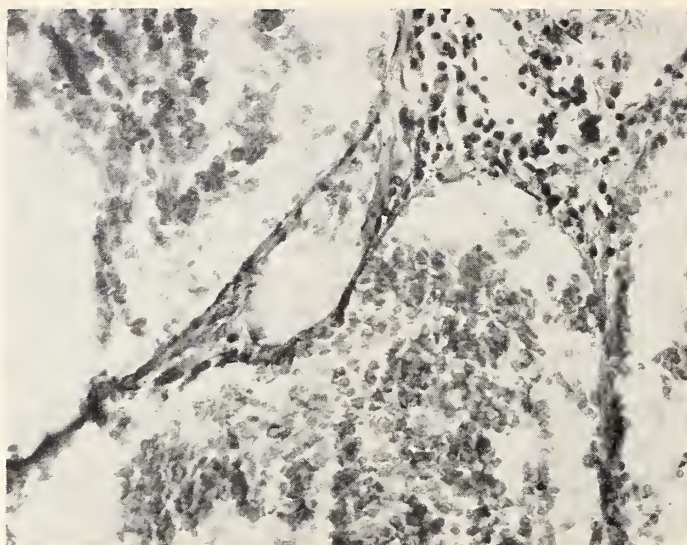


Fig. 3. Focal lymphocytic infiltrates in the stroma. The spaces are lined with flat endothelial cells. Hemotoxylin and eosin.

berg and Angrist¹) to 10 x 7.7 x 5.5 cm. in size (Reiner and Silberg⁵).

Most of the published cases have been found at autopsies. However, Hochberg and Robinson³ in 1950 surgically resected a cavernous hemangioma measuring 9 x 6 x 3.5 cm. Hemangiomas may cause hemopericardium, and five of the reported cases have been associated with it.

Usually visceral pericardium is involved, and only Timme described a case with hemangioma located on parietal pericardium. Histologically, the majority of hemangiomas had a cavernous pattern.

Summary

A case of pericardial hemangioma was described. The lesion was found at autopsy in a 64-year-old Negro male. ◀

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AN INDEX

It is to be noted that a major factor in defining the degree of suicidal threat, and thus the need for hospitalization, was the psychiatrist's own subjective feelings. "If I worry too much, I hospitalize." "It is a matter of my tolerance. If it makes me too anxious, I hospitalize." "My anxiety index is whether or not the patient has given me a disturbing night. If I have been unable to sleep worrying about the safety of the patient, I will hospitalize." Here the patient intrudes into the sleep and dream life of the physician and this becomes the index for action. (Milton Greenblatt: Control Versus Treatment Of The Troubled Mind, *Medical Counterpoint* [Sept.] 1969; pp. 50-57.)



THE DOCTOR'S LIBRARY

TEXTBOOK OF MEDICINE. 12th Edition. Edited by Paul B. Beeson and Walsh McDermott. Philadelphia, 1967, W. B. Saunders Company. 1,738 pages. Single volume \$20.50; Two volume set, \$30.00.

It is doubtful whether many medical textbooks have survived 12 editions and were able to maintain the high standards of the original offering. **TEXTBOOK OF MEDICINE** was published by Cecil 40 years ago. Later it was carried on by Cecil and Loeb, now it is edited by Beeson and McDermott. The format of the latest edition differs. It is smaller in size than its predecessors and this is explained by the fact that the type is smaller, allowing more lines to the column. Two hundred and twenty-six of the articles are newly written and 57 of these are on subjects not included in the 11th edition. The volume represents the efforts of 169 contributors and associate editors.

This review was delayed because it takes time to peruse the various chapters. The book contains a huge mass of data that was well compiled, edited, and summarized. Physicians will find most of the reference material that they need in their practice. The medical student will find this textbook an excellent source of knowledge relative to the common diseases, including many newcomers such as immunoallergic syndromes and hereditary defects.

My main objection is the set-up of the index. The reader is forced to search for certain disorders through a cross-reference rather than directing the reader to the appropriate page. For example, under hepatic coma he is told to see coma. Vitamins are listed, but when looking up vitamin C, the reader is referred to ascorbic acid. After doing this several times, the reader obviously gets discouraged.

T. R. Van Dellen, M.D.

AN INTRODUCTION TO THE HISTORY OF GENERAL SURGERY, Richard Hardaway Meade, W. B. Saunders Company, Philadelphia, 1968.

The author states in his Preface that he has attempted to sketch the major advances in surgery since the Smith Papyrus. He also clearly indicates that he has not attempted to describe the development of surgical specialties, but rather has been concerned with the surgery and the progress in the field of surgery over the many years encompassed by the book. The volume concludes with a chapter on organ transplantation written by Dr. James Hardy, professor and chairman of the department of surgery, University of Mississippi.

The book begins with a description of the evolution of anatomy, the management of wounds, and the management of infection through the years. Later chapters are concerned with specific areas of surgery, such as surgery of the thyroid and parathyroid, surgery of the breast, and similar descriptions according to organ systems.

The task of compiling such a book is formidable, and by necessity the descriptions must be brief. This reviewer questions the value of a book that attempts to present a comprehensive view of such a large subject, particularly when certain inaccuracies or omissions appear in the volume. For example, the discussion of the position of Ambroise Pare in the sixteenth century leaves something to be desired. In discussing Pare's accomplishments, mention is not made of his promotion from barber surgeon to a member of the Faculty of Medicine, a significant transition for a barber surgeon in the Sixteenth Century. Similarly, mention is made of Ludwig Rydiger who performed an unsuccessful pylorectomy for cancer prior to the successful gastric resection by Billroth. It might be

added that in November of 1881, Rydiger performed the first successful resection for ulcer. In the chapter on the development of surgery of the gall bladder and bile ducts, the section head, entitled, "Cholecystectomy," is obviously an error and cholecystostomy is meant to be the subject of the section. Although the reference is given for the publication of J. S. Bobbs, the text fails to mention that he generally receives credit for performing the first cholecystostomy. Half a page is given to a discussion of the role of Trasylol in the treatment of pancreatitis.

These and similar omissions detract from the book. However, the references provided are extensive and comprehensive. The chief value of the book probably is that it can serve as a source of reference for those who would desire more detailed study of a particular subject.

John M. Beal, M.D.

TEXTBOOK OF GYNECOLOGIC ENDOCRINOLOGY, Jay J. Gold, M.D., Editor, Hoeber Medical Division, Harper and Row Publishers, New York, N.Y., 704 pages, price \$23.50.

This outstanding reference book on gynecologic endocrinology is a compilation of the latest information and has 36 contributing authors. It is a well-written text which starts with the basic function of the major glands and expands to include the physiology and pharmacology of the hormones produced. The physiology and pathophysiology are equally well-treated, and the therapy is based on the experience and clear thinking of the authors. The treatment of endometriosis, anovulation, dysmenorrhea, dysfunctional bleeding and other disorders with hormonal products is delineated. Infertility and conception control are included as related subjects, and abnormalities in sexual development are also covered. The succinct yet complete coverage of polycystic ovary syndrome is only one of the excellent chapters as is Dr. Gold's chapter on laboratory studies.

The usual drawback of multi-authored texts is the lack of correlation of one author's material with another's with the resulting duplication of some subjects. But this does not happen to any great extent in this volume. The approach of this book is for the most part clinical rather than experimental. The book is well-printed; and the illustrations, charts, and photomicrographs are beautiful and clear.

The author has presented a unified text and it is recommended as being of great help to all interested in gynecologic endocrinology and its problems.

Paul D. Urnes, M.D.

INFECTIOUS DISEASES AND GENERAL MEDICINE—The Historical Unit, USAMEDS, Walter Reed Army Medical Center, Superintendent of Documents, Government Printing Office, Washington, D.C., 20402, price \$8.25 (1968).

INFECTIOUS DISEASES AND GENERAL MEDICINE is the third and final volume in the Internal Medicine series of the history of the U. S. Army Medical Department in World War II. It continues the impressive account of the expansion of our knowledge of the etiology, clinical picture, control, and management of a wide variety of infectious diseases, including some about which little or nothing was known before the War, and also records unique clinical experiences in various other aspects of medicine. There are chapters on tropical diseases, allergy, heat casualty, viral hepatitis, heart disease, peripheral vascular disorders, rheumatic diseases, and dermatology. A section also is devoted to psychosomatic medicine.

There are 712 pages with 123 illustrations, 6 plates, 8 charts, 105 tables, and a comprehensive index. It is available for purchase from the Superintendent of Documents.

T. R. Van Dellen, M.D.

"Give a man a fish and he will eat for a day; teach him to fish and he will eat for the rest of his days."—Chinese proverb.

Medical Aspects of Professional Basketball

DAVID C. BACHMAN, M.D./CHICAGO

Providing medical care for a professional athletic team is both a rewarding and enjoyable experience. The physician is able to treat a group with a high motivation index for return to activity. A side effect is the excitement and color of the sport involved.

Prevention

The major emphasis in writing on athletic injuries has been on treatment, which is the most dramatic aspect. This is unfortunate, since the greatest contribution can, and should, be made in the prevention of injuries. Preventive sports medicine can be grouped into three categories: pre-season examinations, conditioning and equipment.

The pre-season examinations for the Chicago Bulls are conducted on the opening day of regular camp. This includes a thorough history, physical examination and urinalysis. Other tests can be obtained as indicated. The function of the physician

in this instance is to evaluate each individual's capacity to participate in the sport. No one should be permitted to participate if there is danger of permanent health liability or disability.

There are several common disqualifying conditions for competitive athletics:

Absolute

Absent organs, e.g. eye or kidney
Blood dyscrasias
Cardiac disease
Unrepaired hernia
Physical immaturity

Temporary

Acute infections
Convulsive disorders
Asthma
Untreated active tuberculosis
Uncontrolled diabetes mellitus¹

Other conditions must be considered for individual athletes and individual sports.

Optimum physical-conditioning is the single most important factor in the prevention of injuries. Conditioning is basically the responsibility of the individual players following guidelines established by team officials. The essence of the conditioning program is year-round physical fitness. The professional basketball season extends from September to April, encompassing about 100 games, including pre- and post-season games. For this sport, condi-



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Dr. Bachman is a Diplomate, American Board of Orthopedic Surgery, a candidate for the American College of Surgeons, and a member of the American College of Sports Medicine.



Figs. 1 & 2 Lateral views showing nasal fractures. Many players have had repeated fractures.

tioning necessarily stresses endurance. In the case of the Bulls, each player is expected to report to training camp in shape. The criteria for determining the adequacy of their conditioning include weight maintenance and distance running times. The off-season program outlined by the coach and trainer with the advice of the physician emphasizes circuit training appropriate for basketball, combined with distance running.

Equipment probably plays a lesser role in basketball than in other sports, but the concepts remain the same. Ill-fitting equipment pre-disposes to injury. In contact sports, such as football, faulty equipment may lead to fatality. The team physician, with the trainer, should supervise the fitting of equipment; he may be able to prevent permanent disability.

A great deal has been written regarding routine of ankle-wrapping. The Bulls' policy is mandatory taping for each practice and game. Failure to comply results in an automatic \$25.00 fine. During the past two seasons, we have had only one episode of game-time loss from an ankle sprain. This occurred when a player failed to tape because he was late for practice. Our experience supports the advisability of routine wrapping.

The use of ergogenic aids and drugs is mentioned for one reason—to condemn it.

There is no substantive medical evidence that drugs can benefit or improve athletic performance. There is overwhelming proof that the usual compounds, e.g., amphetamines, androgenic hormones, barbiturates, etc., have a long-term deleterious effect. There should be no discussion on the permissibility of their use.

Treatment

The aim in treatment of athletic injuries is the return to pre-injury level of performance. If this is not accomplished, the athlete's value as a player is diminished, or possibly negated.

The most important aspect of treatment is prompt and accurate diagnosis. The optimum time for diagnosis is at the time of injury. Not only can the mechanism be observed, but evaluation can be carried out before physical signs are masked by edema and restriction of motion secondary to pain. The initial treatment can be carried out under personal supervision, diminishing the chance of secondary injury through ineffective splinting and transportation. This, naturally, requires the attendance of the team physician at the games.

Definitive treatment should be carried out with optimal facilities as promptly as feasible. Delay in treatment prompts only one thing—delay in recovery and return to competition. Individualization and im-



Fig. 3 AP view of wrist showing non-union of carpal navicular. Patient is seven months post-fracture.

provization, utilizing protective padding and strapping can often return a player with a minor injury to competition early and safely; however, no one should be permitted to compete where there is risk of permanent disability or long-term loss to the team. Injecting novocaine to mask pain and allow a player to continue is unacceptable, and should be prohibited.

The conservative approach to operative treatment is prompt surgical intervention when indicated. The radical approach, on the other hand, is procrastination or non-surgical treatment when indicated. Early and accurate repair furnishes the best chance for full recovery of function; delay worsens the prognosis.

The job of the trainer in professional sports is important, since he supervises the day-to-day care of the players. The tendency is toward professionally-qualified trainers rather than ball boys promoted to ankle-wrappers. Many are physical therapists, and most belong to the national organization of athletic trainers which is upgrading their training and qualifications. The trainer for the Bulls has done work toward a Master's Degree in Health Education and Athletic Training.

There are several factors that play a role in developing an effective team physician. An understanding of the basic principles of the sport facilitates his understanding of injuries, and improves his approach to

treatment. The establishment of rapport and mutual respect between team officials and the physician makes the judgment of the athlete's readiness for competition a participatory one, and eliminates a possible source of friction. If the physician lacks understanding, or attempts to be authoritarian in his approach, the job can be frustrating. Probably the most important factor is that the physician have a genuine interest in all of the players, and be willing to give his time as necessary.

Case Presentations

Basketball in the N.B.A. is a contact sport. It is a physical game played by large men. Fortunately, most injuries are minor, e.g., contusions, abrasions, hematomas, finger injuries, nose fractures (Fig. 1 & 2), etc. The reason for this is predom-



Fig. 4 AP view of wrist after removal of cast following graft. Trabeculae are apparent across the fracture line.

inantly because of superb physical-conditioning. Professional basketball players are probably the best conditioned group of professional athletes.

The minor ailments are cared for by the trainer, utilizing the usual modalities: ice packs, hydrocalator packs, whirlpool, ultrasound and protective padding and taping.

In the past several years, we have had few time-loss injuries. One was the ankle sprain already mentioned. Another was an incomplete tear of a medial collateral ligament occurring when an opponent fell on a fallen player. This was treated by immobilization, then protective taping and early return to function. A severe adductor strain necessitated a loss of time of 10 days. This probably could have been prevented by more adequate pre-season conditioning. An abdominal-wall hematoma



Fig. 5 Oblique view of ankle showing small loose body between medial malleolus and talus.



Fig. 6 AP and lateral view of tibia showing periosteal reaction, cortical thickening and a fracture line in the middle third of the anterolateral cortex.

with intraperitoneal hemorrhage caused by an elbow necessitated hospitalization for one week and a time loss of two weeks. An elbow subluxation with secondary traumatic synovitis occurred in the next to the last game last year. This player normally would have missed three to four weeks of the season had it occurred earlier. Five months later, he still has a 10° flexion contracture.

There has been necessity for only two operative procedures: The first was to graft a non-union of a carpal navicular fracture that occurred while the player was still in college. More effective and longer immobilization at the time of the initial injury would probably have made surgery unnecessary. The patient is 18 months postoperative, and has been asymptomatic since removal of the cast. He remains one of the Bulls' scoring leaders (Fig. 3 & 4).

The second procedure was for the removal of a loose body from an ankle joint that caused symptoms when it became locked under the medial malleolus; this had occurred on several occasions. Fortunately, this was able to be popped loose during the season so that surgery could be postponed until after completion of the season (Fig. 5).

One player sustained a tibial stress fracture while playing in the Eastern league. When he arrived at training camp a year later, this was still present, but only mini-

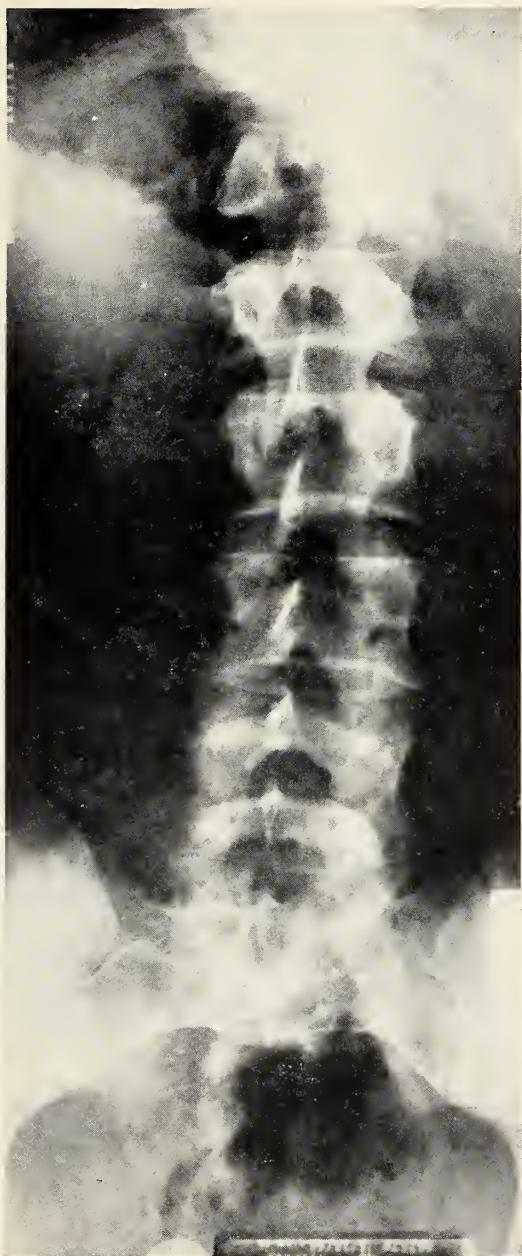


Fig. 7 AP view of lumbar spine showing slight scoliosis and, on close inspection, an enlarged transverse process on the left at L-5.

mally symptomatic. He was later cut from the squad (Fig. 6).

Not all problems are related to injury. Congenital anomalies and degenerative disease play a role in disability. One player has unilateral sacralization of L-5 with a secondary scoliosis that is now giving him only mild symptoms. These are controlled

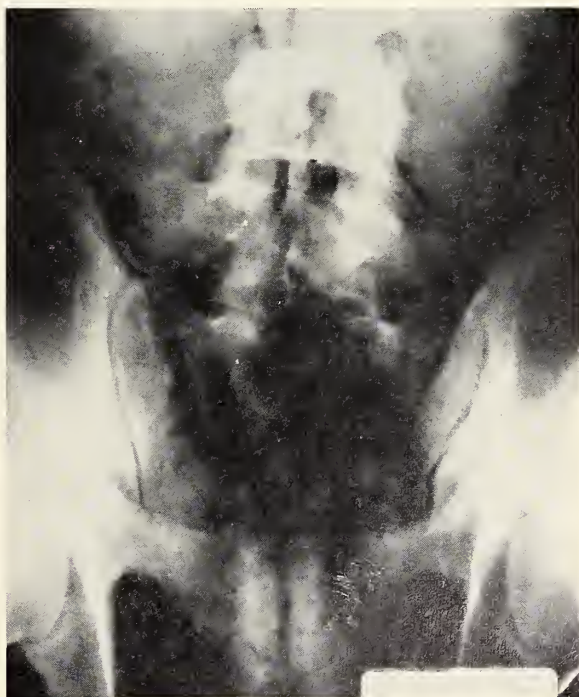
by his total physical-conditioning, supplemented by postural exercises (Fig. 7 & 8).

Another player developed a painless effusion in the knee without history of specific trauma. A diagnosis was finally made, utilizing laminograms, which showed impingement of a femoral and tibial osteophyte on weight-bearing. This subsided spontaneously.

Many players have anterior tibiotalar osteophytes secondary to repetitive forced dorsiflexion of the ankle. Fortunately, none of our players have been disabled by this, although surgical intervention has been necessary on some teams (Fig. 9 & 10).

A final player has developed degenerative arthritis of the first metatarso-phalangeal joint of the foot. This has been controlled by occasional hydrocortisone injections. He will probably require an arthroplasty for control of his symptoms when he is older.

Fig. 8 AP view of lumbosacral junction in same patient (Fig. 7) showing much better detail of large transverse process and illustrating value of upshot view.



Summary

The general concepts of prevention and treatment of athletic injuries have been discussed. Illustrative case presentations show a few of the physical problems that afflict professional basketball players. Though the job of team physician may be time-consuming and require some sacrifice of personal convenience, the job is worth the effort. ◀

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(Ed. note: This is the second in a discontinuous series of articles on the medical aspects of various sports.)



Fig. 9 Lateral view of ankle showing small anterior tibia and talar exostoses.



Fig. 10 Lateral view of ankle showing much larger talar exostosis that appears to have been broken off. There is a smaller loose body in the joint adjacent to it. This also illustrates an elongated posterior talar process (Stieda's process) that can fracture and cause symptoms.

THE CYCLE OF CIVILIZATIONS

Beginning with bondage it moves to spiritual faith,
Then from spiritual faith to courage,
From courage to freedom,
From freedom to abundance,
From abundance to selfishness,
From selfishness to complacency,
From complacency to apathy,
From apathy to fear,
From fear to dependency,
And from dependency back to bondage.

(Author and source unknown)

Film Reviews

A new film on sex education entitled, "A Look At Sex Education in the Schools," is now available from the American Medical Association. Recommended for showing to medical societies and Auxiliary groups, the film is available at no charge by contacting: AMA Radio, TV and Motion Picture Dept., 535 N. Dearborn St., Chicago 60610.

* * *

The documented story of America's raging VD epidemic has been put on the screen for the first time in a film co-sponsored by the American Social Health Association. Entitled, "VD: A Call To Action," the 16-mm color film runs 27 minutes and is available for a \$20.00 rental fee from: Robert Mitchell, President, Assoc. Films, 600 Madison Ave., New York, N.Y. 10022.

* * *

A 30-second color film on safety in the use and storage of medicines is now available for public service programming by contacting: Council on Family Health, 485 Madison Ave., New York, N.Y. 10022.

"False Friends" is the title of a 9-minute color film which shows the various effects of using heroin or opium. The film introduces, through animation, a laborer and the problems he and his family face as a result of his addiction. A brief section is also devoted to rehabilitation of the addict and his cure when he is once again united with his family. Contact: International Film Bureau Inc., 332 South Michigan Ave., Chicago 60604.

* * *

"The Mark Waters Story," an anti-smoking movie based on a dramatic true story, is now available to community groups. The film, recreating the heartbreaking but heroic drama of a newspaperman who wrote his own obituary while dying of lung cancer, stars TV and motion picture actor Richard Boone. The 25½-minute, 16mm color film is available on request from: Modern Talking Picture Service, 2323 New Hyde Park Rd., New Hyde Park, New York 11040.

Official Call for Scientific Exhibits 1970 Annual Meeting of ISMS Chicago - - May 18, 19, 20

The Committee on Scientific Assembly invites members of the Illinois State Medical Society to submit applications for scientific exhibits at the Society's 1970 annual meeting, May 18-20 at the Sherman House Chicago.

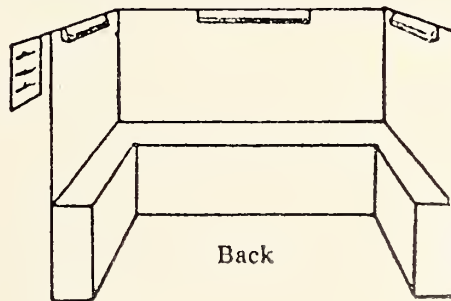
To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space at the meeting are requested to file an application before March 15, 1970, giving the basic equipment which will be needed. Awards are given exhibits of exceptional value. *Assignments are made after exhibits have been approved by the Committee on Scientific Assembly.*

There is no fee charged for scientific exhibits, but the exhibitor must pay the cost of installing the exhibit, of tables and chairs that may be rented, for alteration in shelves, equipment or construction. Single exhibit space is 8 x 10 feet.

Those interested in providing an exhibit are requested to file an application and a

full description of the exhibit. DEADLINE FOR APPLICATIONS: March 15, 1970.

CONTACT: Dr. J. Robert Thompson
Director of Exhibits
Illinois State Medical Society
360 North Michigan Ave.
Chicago, Illinois 60601



Single Exhibit Size—8 x 10 ft.



THE VIEW BOX

BY LEON LOVE, M.D.

*Director, Department of Radiology, Loyola University Hospital
and Chairman, Department of Radiology, Loyola University
Stritch School of Medicine*



Fig. 1

The patient is a 50-year-old white male who entered with a previous history of having known rheumatic heart disease with mitral insufficiency. At this time he is somewhat short of breath and has a temperature of 100. Physical examination revealed rales in the lung bases. A pan-systolic mur-

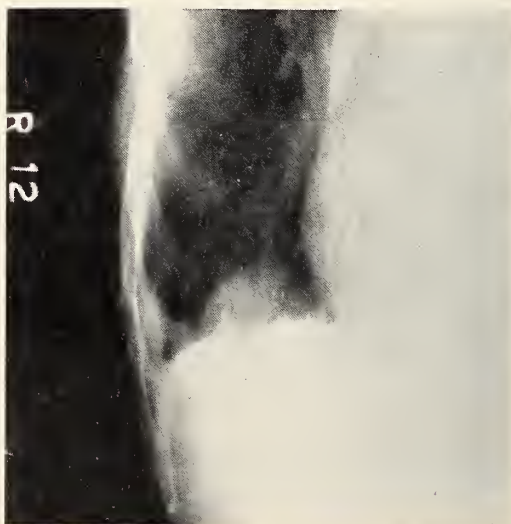


Fig. 2

mur with mid-diastolic rumble at the apex which radiated to the axilla was present. What's your diagnosis?

1. Pulmonary infarcts
 2. Carcinoma of the lung
 3. Pneumonitis
 4. Encapsulated areas of effusion on the basis of cardiac decompensation
- (Answer on page 196)

MANUSCRIPT INFORMATION

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed.

Manuscripts should be typed, double spaced, and submitted in duplicate, one original and one carbon. An article should not exceed **12 to 16 manuscript pages**, (including illustrations) and should be briefer if possible.

References should be numbered and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

Address manuscripts to:

T. R. Van Dellen, M.D., Editor
Illinois Medical Journal
360 N. Michigan Ave.
Chicago, Ill. 60601.

Obituaries

***Joseph T. Arida**, Joliet, died Nov. 18 at the age of 37. He was born in Tanta, Egypt.

Joseph G. Berkowitz, Chesterton, Ind., died in Dec. at the age of 87. He was founder of the Public Health Institute of Chicago.

***William W. Billings**, Alton, died Dec. 8 at the age of 76. For many years he was coroner of Madison County.

***Maurice W. K. Byrne**, Chicago, died Dec. 29 at the age of 77. He was on the staff of Mercy hospital and a member of the American College of Surgeons. He was a member of the ISMS Fifty-Year Club.

Ethel F. Cooper, Peoria, died Dec. 10 at the age of 81. She did much volunteer medical work under auspices of the Peoria YWCA.

***Martin S. Croft**, Chicago, died Sept. 28 at the age of 67.

Joseph R. Franco, Lombard, died August 5 at the age of 65.

***John H. Freeman**, Oak Park, died Nov. 23 at the age of 60. He was a Diplomat of the American Board of Obstetrics and

Gynecology and a Fellow of the American College of Surgeons.

***Albert Havens**, New Philadelphia, died at the age of 94. He was a country doctor for 66 years and a member of the ISMS Fifty-Year Club.

***Elliott F. Parker**, Moline, died Dec. 23 at the age of 68. He was past president of the Rock Island County Medical Society.

***Carl M. Pohl**, Oak Park, died Dec. 11 at the age of 62. He practiced at West Suburban hospital, which his father helped found.

***George A. Telfer**, Hillsboro, died Sept. 15 at the age of 79. He was past president and past secretary of the Montgomery County Medical Society. He was also a member of the ISMS Fifty-Year Club.

***E. Perry Vaughn**, Chicago, died Dec. 5. He was a staff physician at Martha Washington Hospital.

***Charles Weissman**, Hammond, Ind., died Dec. 24 at the age of 58.

*Indicates Member of Illinois State Medical Society.

The Other Side Of The Coin

BY WILLIAM BAUER, M.D./DEKALB

Schizophrenia and criminality (or delinquency) appear to be very closely related—two sides of the same coin, so to speak, just as Thomas Jefferson and Monticello stand combined on opposite sides of our five cent piece.

Choice Not Fortuitous

The "choice" of a life pattern does not appear to be altogether fortuitous. If the child has an opportunity to act out (externalize) feelings resulting from a pathological primal family triangle, depending upon the nature and intensity of those feelings, he will experience, in all probability, a lifetime of characterological distortion. If, on the other hand, the child is controlled (constricted) to the extent that no externalization can occur, necessity dictates a more primitive and less adaptive, albeit less destructive (outwardly) response—the child begins to indulge these same primitive feelings in fantasy and autistic endeavors (television often seeming to gratify the need for fantasy fulfillment artificially).

Final Determinant

The final determinant (as to whether the conflict is externalized or internalized) seems to be whether or not the superego (parental and social authority) can be overthrown or ignored. Some genetic predisposition toward activity or passivity probably also plays a role in this great choice.

Father No Longer Autocratic

In our time, the cultural superego has lost its rigidity. The father is no longer the autocrat in the home, the social system is more tolerant in general. Consequently, the child has a greater opportunity to externalize and act out pathological unconscious strivings.

Acting Out May Be Categorized

The types of abnormal or maladaptive behavior (acting out) which we see may be categorized in relationship to the original Oedipal conflict:

1. The child who is acting out his anger and hostility at having been raised by unloving, ungiving (immature) parents.⁷ The rejected child.
2. The child or adolescent who is acting out (or displacing his anger to society) his anger at having come to sense the lack of integrity (phoniness) of his parents; the hypocrisy and deceit — the

William Bauer, M.D., is a DeKalb psychiatrist. He is Medical Director, DeKalb County Mental Health Center and Chief, Psychiatric Service, DeKalb Public Hospital.



double standard which has played such a prominent role in post-war suburbia. The smug materialism and the superficial veneer of morality which does not provide depth or meaning to the adolescent's life. (The "hanging-on to tradition" that "affects" many middle-aged parents.⁶)

3. The child or adolescent who is acting out the unconscious wish (long since repressed) of one or the other parent involved in a marriage characterized by a ruptured, unstable, or weakened emotional bond.

4. The adolescent who is resentful of poor protoplasmic (intellectual) endowment who seeks to gain stature in his peer group by becoming more daring or more violent than the others. The brain damaged and constitutionally inferior children fall in sub-categories within this group.

5. The adolescent who has had poor parental and social models for superego formulation. "The child internalizes . . . not only the positive, socially consistent attitudes of the parent, but also the frequently unexpressed, ambivalent, anti-social feelings."⁵

6. The child who is ego deficient and fears unduly the rejection of his own peer group.³

7. The psychotic or borderline psychotic adolescent.

All Nonadaptive

All of these externalized strivings listed above are, of course, just as maladaptive as the internalized fantasy strivings of the schizophrenic; but are much more destructive to society in terms of property damage, potential loss of life, self-destructiveness, and violence in general. This is the great problem of today. How do we cope with the new unrest and increase of externalization borne of inadequate emotional bonds between parents combined with a blurring of social definitions (weakening of superego)? First, of course, is to make an accurate diagnosis, if you will; then, a logical approach can be followed in the treatment of each specific type of violence (which is only a symptom of the underlying emotional illness). For illnesses in each category, the treatment is naturally somewhat different.

The Rejected Child

Rejection may be overt or covert; the latter being by far the more insidiously corrosive to the child's sense of self respect and self confidence—the double meaning and veneer of "love" producing serious defects in the child's capacity to evaluate reality appropriately. The increased utilization of denial and repression lead invariably to increased alienation from unconscious drives and feelings which ultimately control behavior (lead to acting out of anger and hostility) when split off from awareness in such a manner. When rejection is open, it can be accepted eventually and the child can find acceptable surrogate object relationships.

Lack of Parental Integrity Perceived

Perhaps the most important cause of present day violence and protest is the lack of integrity and the hypocritical sense of values that has characterized the great "middle class" of America too long. The child is told one thing and the parents do something else entirely differently, excusing this by saying, "Do as I say, not as I do." For example, "Money is not the most important consideration, Dear," when it most obviously is the most important consideration. Also, "Of course, we are good Christians, we go to church, don't we?" (while destroying a business competitor ruthlessly). Another good one, "Of course your mother and I love each other. Just because we hurt each other doesn't mean we don't love each other." (Tsk, tsk!) Or better yet, "I'm doing this (to you) for your own good because I love you." Wow! The list goes on and on. The credibility gap increases, anger is displayed to society in general, and we have violence as a behavioral trend in America.

Acting Out Unconscious Wish of Parent

Joining in with these protestors are the youngsters who seize every opportunity to act out the unconscious hatreds of one or more parent, usually spawned in the context of a distorted emotional bond between the two parents long, long before. For example, mother unconsciously hated her husband (a father figure to her) and turned for support to an emotional marriage with her son. For years, this boy perceived that the mother would like to act

violently toward her legal husband. The boy carries this unconscious striving around with him for years—repressed and deep in the unconscious—displaces it to society and, when the occasion presents itself, acts out in violence. Violence then, is the other side of the schizophrenic coin—tails instead of heads, and we all lose,—externalized schizophrenia rather than the conventional internalized type born of totalitarianism.

The Poorly Endowed

The adolescent who is reacting to poor protoplasmic inheritance is smarting from hurt and resentment. These feelings are often deeply repressed; but given the opportunity (weakening of the superego and group support), this child also becomes potentially violent. In the adolescent, behavior often becomes delinquent as he strives for identity or becomes frustrated by increased social demands on his limited abilities.² This type of person must be helped to realize that he too is uniquely capable of creative activity and productivity of some type.

The Psychopath

The adolescent who has had relatively little superego modulation or who suffers from various scotomatae of the superego, joins the destructive group gleefully since he is not capable of realizing the significance of such behavior, feeling no guilt or anxiety concerning the matter, and failing to comprehend the maladaptation involved. Aichhorn (1925) indicated long ago that success in the treatment of this type of delinquent is often attributed to the fact that libidinal adjustments are attained in the direction of sublimation and compensation through the process of developing a strong, positive identification with a significant authority figure,² who is in a position to effect concerned, but firm, behavioral controls.

Need for Acceptance

Adolescents need to feel accepted by their peers. However, this need appears to be intensified in those who have not differentiated sufficiently (gained sufficient ego strength to maintain his own individuality). This weakness appears to be related to several factors: feelings of inadequacy, lack of appropriate identifica-

tion, and a thwarted development of aptitudes and other inherent capacities. The child who is attempting to gain the support of his peers by following them in violence needs support in the development of his own strengths. This is often acquired fairly quickly when the adolescent is able to form a positive identification with an accepting staff member or other parent surrogate.

Presented with Distorted Reality

The psychotic adolescent has been presented with such a distorted picture of reality and has been overwhelmed with so much unpleasant material from the past which was never brought out in the open (discussed with the parents) that he has very little capacity to interpret his environment in a healthy manner. In view of the fact that he could not trust his own parents to supply him with a true picture of reality and consequently could not depend upon them for gratification of very basic needs, i.e., security, it is highly unlikely that he would be capable of trusting anyone to the point of emotional involvement. This is, of course, the task of the therapist who, in this instance, must be very skilled and highly trained to effect such an involvement. This type of adolescent (and the borderline psychotic) needs all the support that he can get from a person that he can trust. This relationship should be established as quickly as possible—as soon as school officials become aware of the difficulty.

Prophylaxis Possible

When large numbers of adolescents are brought together, as in a campus setting or other institution, adequate screening and testing facilities may be provided to detect the potentially disturbed who are prone to externalize or "act out." This screening can be accomplished readily by experienced psychologists, psychiatrists, social workers, or other trained interviewers. These adolescents should then be exposed prophylactically to counseling or other forms of therapeutic involvement to minimize riots and other acts of violence. Group therapy seems particularly apropos for this type of patient when large numbers are involved.

When brain damage is suspected, certainly psychological testing and an EEG

would go a long way toward establishing the degree or extent of damage. Appropriate counseling then might help channel the individual's energies along the lines of aptitudes and remaining capacities. This, of course, would be more rewarding and personally gratifying in that otherwise inevitable frustrations and disappointments of having to compete with those more capably endowed intellectually would be avoided.

Summary

The conjugate relationship between schizophrenia and delinquency has been described.

An outline has been provided which allows for more specific definitions of the different types of youth prone to violence.

It has been suggested that youth demonstrating strong tendencies to act out in a violent manner may be detected by relatively simple screening procedures.

Potentially violent externalizers may be detected upon admission to the university or other large peer groups and specific pro-

phylactic measures (treatments) may be instituted^{4,1} to prevent the eruption of campus rioting, mob violence, etc.

Throughout, it is contended that non-adaptive externalization deserves the same intensity of psychiatric consideration that other more classical forms of mental illness now receive. ◀

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Mental Health Care Improving In Rural America

What is the outlook for better mental health care for Americans living in the rural areas of the Nation? Due to a federally funded community mental health program, it is brighter than at any time since the rise of the large custodial mental hospital.

In a recent tabulation of the growing number of community mental health centers, the National Institute of Mental Health reports that centers are now slated for 23% of the country's rural county population. These centers will bring mental health services within reach of millions of Americans, most of whom never before had access to community-based care and alternatives to hospitalization.

In 11 states, centers to be created with the aid of Federal construction and staffing grants will cover more than one third of their rural county populations.

Of the 500 poorest counties in the country, 486 are rural. Funded centers will serve 122, or 25%, of these.

Of the 3,134 counties in the United

States, 2,160 are outside of standard metropolitan statistical areas, and more than 50% of their residents live in communities smaller than 2,500.

Most of the 134 new rural centers will cover several counties, using mobile treatment teams or satellite clinics. They will provide a comprehensive range of services, as required by the Federal aid program: inpatient and outpatient care, emergency services, day or night care (partial hospitalization), and consultation and education for physicians, schools, clergy, and local agencies.

Since the first Federal grant for community mental health centers was awarded in 1965, more than 350 centers have been funded in 49 states, Puerto Rico, and the District of Columbia, covering areas in which more than 54 million Americans reside. By 1980, some 2,000 centers are projected by the national community mental health program. A total of \$218,547,589 was expended in Federal aid for centers by the end of fiscal year 1968.



public affairs library reviews

MAN VS. THE WELFARE STATE. By Henry Hazlitt, Arlington House, New Rochelle, N.Y., \$6.00.

You often hear the guaranteed income idea disguised under such synonyms as "income maintenance or negative income tax."

Trick names of this sort, observes Henry Hazlitt, corrupt the language and confuse the thoughts of the American public. He says it would hardly clarify matters to call a handout a "negative deprivation" or having your pocket picked termed as "receiving a negative gift."

Interestingly enough it was Hazlitt himself who put forth a similar proposal some 30 years ago in a weekly, published by the *New York Times*.

Subsequently, he reversed himself after thinking through the horrible consequences. Now he shares his penetrating observations with us in **MAN VS. THE WELFARE STATE**.

In three chapters Hazlitt demolishes the arguments for a guaranteed income and guaranteed job schemes that have popped up recently but he doesn't stop there. He shows why the only real cure for poverty is production and points out that the only

real way to *high per capita income* is maximum opportunity for the competitive enterprise system to function easily and freely.

In an interesting and readable fashion Hazlitt surveys the dangers we face on many fronts as we look ahead to the larger welfare state. Such as: why a planned economy must have controls and regulation; minimum wages and how they hurt those that they are intended to help; the dangers in promising instant utopia and not being able to deliver; inflation and why it is actually the enemy of growth; the social security system and what happened to relief programs that unemployment insurance and social security were meant to replace and why tax the rich philosophy doesn't help the poor.

More than a critical analysis, Hazlitt's book presents positive ideas (and practical ones) for replacing ineffective and high cost programs for something better.

Mr. Hazlitt is well-known for his many contributions in the field of public affairs, government, politics and effective operation of our complex national governmental affairs.

The book will be talked and argued about. It is worth reading.

Read an interesting book lately? Write us a note and suggest its inclusion in the Public Affairs Library—Reviews. The Library appreciates your comments and suggestions.

***ISMS Annual Convention May 17-20
Sherman House, Chicago***

Maternal Mortality In Chicago

Chicago Board of Health

Maternal and Infant Care Project 502

Interim Report

BY STUART ABEL, M.S., M.D., JACK ZACKLER, M.D.
RONALD LEHOCKY, M.D., AND HANCE C. PHILLIPS, JR., M.D./CHICAGO

In July, 1964, the federal government made funds available to the Chicago Board of Health to expand its maternal and infant care project. The expanded program, Maternity and Infant Care Project 502, provides additional services to low income pregnant patients who heretofore have been unable to receive specialized obstetrical attention. In addition to providing routine physical examinations, periodic prenatal exams, and outpatient therapy, the project was designed to include many routine coordinated services such as hemoglobin electrophoresis, Pap smear examination, diabetes screening, family planning services, nutritional guidance, medical social service casework, bacteriuria screening, homemakers service, dental care, health education, and more intensive public health nursing services.

The project strives constantly to evaluate its effectiveness as reflected in the morbidity and mortality amongst the mothers and babies served. The results of the care of the adolescent patient have recently been reported in the *American Journal of Obstetrics and Gynecology*. (Vol. 103, No. 3, pages 305-312, February 1, 1969). In this presentation we will attempt an analysis of maternal mortality amongst the patients in the Project 502 with a comparison to the remainder of the patients delivered in all of Chicago. We will also take note of the outcome in the group designated as high risk. This study was conducted in part by Hance Phillips and Ronald Lehocky, Northwestern Medical School seniors serving a Public Health Clerkship in the Chicago Board of Health under a grant provided by the Illinois State Department of Health.

To reduce maternal and perinatal mortality and morbidity most efficiently special arrangements were made for those patients designated as 'High Risk'. A patient is classified as High Risk if either 1) a *past* pregnancy involved hazardous complications such as previous cesarean section, myomectomy, incompetent cervical os, previous toxemia, chronic nephropathies, hypertension, abortion, Rh sensitization or other coincident medical illnesses, 2) the *present* pregnancy involves potentially hazardous conditions such as toxemia, missed or threatened abortions, placenta praevia, abruptio placenta, ectopic pregnancy, Rh sensitization, positive or suspicious Pap smear or any intercurrent medical or surgical disease or obstetrical abnormalities. In addition, adolescents younger than 15, women 40 years or over and primigravidas over 35 are included. A third category included those patients whose present pregnancy is compounded by mental, social or emotional problems.

Table I illustrates the categorization of 5,218 patients classified as High Risk which were followed to termination by the 502 Project between January, 1966 and December, 1967. More than one complication was present in 15.2% of the total patient group. The highest ranking category for High Risk classification was conception at 15 years of age or younger. This was a factor in 49.3% (2,572) of the total caseload. Of this group 87.3% were eligible for the High Risk program on the age factor alone. A history of previous cesarean section was present in 11.1% (580) of the patients. Toxemia developed in 506 patients as a single complication or compounding another. Diabetes mellitus was a factor complicating 342 cases.

When designated as High Risk, the mother is assigned to one of 11 project affiliated hospitals in Chicago, all having approved obstetrical residencies. She receives her routine prenatal care at the Board of Health Clinic until the seventh month. At that time she is referred to the specialized 'High Risk' obstetrical clinic operated by the assigned hospital. The patient may be referred to the 'High Risk' clinic before the seventh month if specialized care is deemed necessary by the Board of Health physician. The patient may be admitted to the hospital at any time when intensive care is required. From Novem-

ber, 1964, to June, 1968, the project provided care to 78,491 mothers of which 8,956 were classified as High Risk.

Individual histories, Board of Health clinic charts, and hospital records of 107 maternal deaths which have occurred from January 1, 1966 to December 31, 1967 have been reviewed. Analyzing the factors surrounding the death, the Committee on Maternal Mortality determined the relationship of the death to obstetrical causes. In this paper, the *obstetric* mortality rate is used for comparison between the Board of Health Project 502 and the remainder of the city of Chicago. The obstetric death rate is defined by the Committee on Maternal and Child Care of the AMA as the number of maternal deaths due to *direct obstetric causes per ten thousand* live births over the period of 12 months.

In 1966-67, the Board of Health Project 502 cared for an estimated 30,843 pregnancies which resulted in live births. From this patient load, there were 16 maternal



Stuart Abel, M.S., M.D., (above left) graduated from Northwestern University Medical School, is currently Associate Professor of Obstetrics and Gynecology at Northwestern University Medical School, Head of the Obstetrical Service at Passavant Memorial Hospital in Chicago, and is Consultant and Coordinator of Chicago's Maternity and Infant Care Project 502. Jack Zackler, M.D., (above center) is Medical Director, Bureau of Health Services, Chicago Board of Health, and Director of Maternal and Child Health, Chicago Board of Health. A graduate of the University of Illinois College of Medicine, he is an associate professor in OB-GYN, Chicago Medical School. Ronald Lehocky, M.D., (above right) is a pediatric intern, Children's Memorial Hospital, Chicago. He is a graduate of Northwestern University Medical School and was serving a clerkship with the Chicago Board of Health at the time this study was made. Hance C. Phillips Jr., M.D., is currently serving a mixed medical internship at Passavant Memorial Hospital, Chicago. A graduate of Northwestern University Medical School, Dr. Phillips also served a clerkship with the Chicago Board of Health.

Table I.
High Risk Factors In 5,218 Patients Followed
To Termination By The M&IC Project 502.
(January, 1966 to December, 1967)

	NO OTHER COMPLICATIONS	PREVIOUS C-SECTION	DIABETES	ANEMIA	TOXEMIA	HYPERTENSION	RENAL DISEASE	CARDIAC DISEASE	TWINS	ANTE-PARTUM BLEEDING	MISC. COMPLICATIONS	
JUVENILES	2245	5	12	52	82	29	11	33	6	23	74	2572
MULTIPS OVER 40	246	7	21	9	15	47		10	2	7		364
MULTIPS UNDER 40	24	13	17	7	22	10	4	3	5			105
PRIMIPS OVER 35	20					2						22
ELDERLY (OVER 40)	136	9	22	6	7	23	2		1	3		199
REPEAT C-SECTIONS	464		20	8	14	15	5	7	3	10		546
DIABETES	165			4	27	20	5	8	3			232
ANEMIA	83				3	4	5	1	6	1		103
TOXEMIA	324						7	7	6	2		346
HYPERTENSION	92								6	4		102
RENAL DISEASE	36									1		37
CARDIAC DISEASE	129								1	1		131
MISC.	459											459
TOTAL	4423	34	92	86	160	150	39	69	39	52	74	5218

deaths of which 9 were attributable to direct obstetric causes. Two patients died of sepsia, three from hemorrhage, one from toxemia and one from a pulmonary embolism.

Table II provides the breakdown of these cases according to year, and shows that the 1966 obstetric mortality rate was 1.87. In 1967 the rate was higher at 4.04 per 10,000 live births. The combined rate for the 2 years was 2.92.

The obstetric mortality rate in the 502 Project is interesting when compared with that of the remainder of the city of Chicago during the same period. Like the patient population represented by the city of Chicago, the project patient load is randomized and has about the same ratio

of complicated-uncomplicated obstetric cases.

Referring to Table III, 114,029 live births were delivered in Chicago to non-Project patients between January 1, 1966 and December 31, 1967. There were 91 maternal deaths, 60 of which were attributable to obstetric causes. Thus for 1966, the city's Obstetric Mortality rate was 4.49 whereas it rose to 6.04 in 1967. The combined rate for the 2 years was 5.26. These rates are compared to the Project's rates of 1.87 and 4.04 for 1966 and 1967 respectively and a 2 year rate of 2.92 for the Project as compared to 5.26 for the rest of the city.

Between January 1, 1966 and December 31, 1967 (Table IV) there were 5,219 live births to the 'High Risk' patients in the

Table II
Analysis Of The Mortalities In The
Board Of Health M&IC Project 502

	Estimated Live Births	Maternal Deaths	Obstetric Deaths	Mortality Rate
1966	15,990	4	3	1.87
1967	14,853	12	6	4.04
TOTAL	30,843	16	9	2.92

Table III
Analysis Of The Maternal Mortalities In The
City Of Chicago, Exclusive Of Project 502

	Total Live Births	Maternal Deaths	Obstetric Deaths	Mortality Rate
1966	57,785	38	26	4.49
1967	56,244	53	34	6.04
TOTAL	114,029	91	60	5.26

Table IV
Analysis Of The Mortalities In The Board Of
Health Project 502 HIGH RISK Program

	Live Births	Maternal Deaths	Obstetric Deaths	Mortality Rate
1966	2,475	3	2	7.28
1967	2,744	3	1	3.64
TOTAL	5,219	6	3	5.74

Table V
Comparison Of Obstetric Mortality Rates

	City Of Chicago	Project 502	502 High Risk Program
1966	4.49	1.87	7.28
1967	6.04	4.04	3.64
OVERALL	5.26	2.92	5.74

Project. During this period there were 6 maternal deaths, 3 attributable to direct obstetric causes.

The death in 1966 involved a 13-year-old Gravida I with pre-eclampsia who died from general sepsis secondary to peritonitis and endometritis following a primary C-section of a live infant. A 30-year-old Gravida II, Para II patient died in 1967 three days post-partum from a pulmonary embolus. The second obstetric death in 1967 involved a 23-year-old Gravida IV, Para IV patient with coarctation of the

aorta whose death followed amniotic fluid embolization a few hours after C-Section.

As expected, the High Risk death rate was higher than both the Project rate and the city rate in 1966. In 1967, however, for reasons which are not clearly obvious, the mortality rate in the High Risk segment of the Project was less than both the city and Project rate. A comparison of these rates is made in Table V. It is obvious, of course, that several of the conditions which led to mortality appeared in the intra partum or post partum period and would not

have been included in the High Risk group.

Comparing the types of patients in the 502 Project with those in the city in general is admittedly difficult. Granted, the 502 patients are predominantly from the lower socio-economic groups and many of the remaining patients in Chicago received the benefit of private care. But we must not lose sight of the fact that the 'remainder group' also included many of the lowest socio-economic patients who were not

motivated enough to seek any care at all and who appeared for the first time in many instances for delivery.

Figures which are factual are presented and the reader may reflect on their significance, which must remain somewhat conjectural. Figures presented are valid but the total mortalities are admittedly low enough to cast doubt on the existence of any really significant trends thus far. However, the comparison speaks well for the effectiveness of Project 502 to date in terms of maternal mortality. ◀

Clinics for Crippled Children Scheduled

Twenty-six clinics for Illinois' physically handicapped children have been scheduled for March by the University of Illinois, Division of Services for Crippled Children. The Division will count 22 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be three special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

March 3—Alton—Alton Memorial Hospital
 March 3—Carrollton—Boyd Memorial Hospital
 March 4—Hinsdale—Hinsdale Sanitarium
 March 4—Carmi—Carmi Township Hospital
 March 4—Jacksonville—Norris Hospital
 March 5—Sterling—Community General Hospital
 March 5—Effingham—St. Anthony Memorial Hospital
 March 10—Peoria—St. Francis Children's Hospital
 March 10—East St. Louis—Christian Welfare Hospital

March 11—Champaign-Urbana—McKinley Hospital
 March 11—Joliet—St. Joseph's Hospital
 March 12—Springfield—General—St. John's Hospital
 March 12—Macomb—McDonough District Hospital
 March 13—Chicago Heights—Cardiac—St. James Hospital
 March 17—Belleville—St. Elizabeth's Hospital
 March 17—Rock Island Area—General—Moline Public Hospital
 March 18—Evergreen Park—Little Company of Mary Hospital
 March 18—Springfield Cerebral Palsy—Diocesan Center
 March 19—Decatur—Decatur Memorial Hospital
 March 19—Elmhurst—Cardiac—Memorial Hospital of DuPage County
 March 19—DuQuoin—Marshall—Browning Hospital
 March 24—Peoria—St. Francis Children's Hospital
 March 25—Rockford—St. Anthony Hospital
 March 25—Centralia—St. Mary's Hospital
 March 25—Elgin—Sherman Hospital
 March 27—Chicago Heights—Cardiac—St. James Hospital

WHAT "GENERATION GAP"?

BY MATTHEW B. EISELE, M.D., CHAIRMAN
COUNCIL ON PUBLIC RELATIONS & MEMBERSHIP SERVICES

Following the student protests at last summer's AMA meeting, there were claims that the medical profession was split by a serious generation gap. America's future doctor was characterized as a rebel, bent on revolutionizing every aspect of medicine.

But is the shout of the noisy radical really the voice of the new physician? Is there really a medical "generation gap"?

ISMS attempted to find the answer recently through a comprehensive survey of medical students, interns and residents. The survey incorporated the same questions asked of ISMS members in the 1969 *IMJ* Survey on Major Issues.

The results—based on nearly 1,000 responses—prove that despite claims to the contrary, there is little if any generation gap. Indeed, on 24 out of 27 issues, students, interns and residents are in full accord with ISMS members. For example, there is agreement that:

- An education campaign for a liberalized abortion law should be launched.
- Methods for curbing the profession's "bad apples" should be improved.
- County medical societies should be active in developing local mental health services.
- Residents and interns should receive some training in neighborhood health centers.
- Research funds to universities should not be tied to the university's production of physicians.

Naturally the degree of harmony differs from one issue to another, but in only three cases is there outright disagreement—on employment of physician's assistants and voluntary service in a community health center.

The survey questionnaire is reproduced in full on the following pages, along with the responses (on a percentage bases) of residents and interns, and of medical students. For comparison, the responses of the 3,500 ISMS members who answered the survey also are noted. About 350 of 950 medical students in Illinois answered the survey, and 550 of 2,700 interns and residents responded.

1969 SURVEY ON MAJOR ISSUES

		ISMS Residents, Members Interns Students		
1.	Stimulated by last year's ISMS opinion survey, your House of Delegates approved liberalizing Illinois' therapeutic abortion laws. Should ISMS initiate an educational campaign to achieve this goal?	Yes No	77% 23%	83% 17% 90% 10%
2.	Chiropractors are seeking authority to give school physicals, serve on medical advisory boards, collect from governmental and private health insurance programs. Should ISMS intensify its legislative and educational efforts against such moves?	Yes No	89% 11%	88% 12% 84% 16%
3.	Medical Economics recently reviewed the problem of "bad apples" in the profession, suggesting medical societies lack the power to curb the unethical practitioner. Do you think ISMS should:			
	a. Encourage legislation establishing a state disciplinary board—separate from the medical examining board—to investigate physicians suspected of serious misconduct? Such a board—composed of doctors—would have authority to recommend suspension or revocation of licenses.	Yes No	77% 23%	83% 17% 76% 24%
	b. Contract legal services for the purpose of investigating doctors (including non-members) and presenting evidence of suspected misconduct to the state?	Yes No	52% 48%	49% 51% 50% 50%
	c. Inform the public—through an education program—of what factors constitute unreasonable fees or unethical practices?	Yes No	75% 25%	76% 24% 85% 15%
4.	Should ISMS and county medical societies require local peer reviews of physicians when evidence indicates incompetence due to age, sickness, or other causes?	Yes No	82% 18%	87% 13% 83% 17%
5.	If peer review determines that a physician is incapable of practicing medicine, should the county or state medical society recommend to the Department of Registration and Education that his license be restricted or withdrawn?	Yes No	76% 24%	81% 19% 80% 20%
6.	It is charged that the federal government, through research grants, indirectly discourages medical schools from graduating more physicians. Should medical schools be required to graduate a certain number of doctors in proportion to the amount of federal research funds received directly or through staff researchers?	Yes No	41% 59%	27% 73% 27% 73%
7.	State law permits communities or counties to establish local mental health services through imposition of a tax levy, approved by local referendum. Should county medical societies:			
	a. Support such referendums in areas without adequate mental health services?	Yes No	77% 23%	91% 9% 91% 9%
	b. Initiate such referendums?	Yes No	59% 41%	78% 22% 84% 16%
8.	In most cases, the Department of Mental Health limits hospital admissions to only "high risk" individuals whose need for hospitalization is imminent or mandatory, while individuals with less severe disturbances are referred elsewhere. Should ISMS support the Department in this policy?	Yes No	62% 38%	51% 49% 46% 54%

		ISMS Members	Residents, Interns	Students
9.	Your House of Delegates has emphasized that alcoholism is primarily a health problem. Should ISMS seek legislation providing medical care for arrested chronic alcoholics?	Yes 75% No 25%	80% 20%	86% 14%
10.	To reduce patient stays in hospitals, do you favor:			
	a. Handling all diagnostic workups on an outpatient basis, provided the patient's condition permits and insurance coverage is available for such services?	Yes 92% No 8%	95% 5%	88% 12%
	b. Performing minor surgery on an outpatient basis, provided insurance coverage is available for such services?	Yes 96% No 4%	94% 6%	90% 10%
	c. Encouraging insurance carriers to provide comprehensive coverage, including outpatient and home care?	Yes 96% No 4%	97% 3%	99% 1%
11.	Because of the rapid expansion of medical knowledge, some observers have urged compulsory relicensure examinations for physicians. As an alternative, would you favor participation in a continuing medical education program as a requirement for:			
	a. Membership in your specialty society or AAGP?	Yes 74% No 26%	80% 20%	78% 22%
	b. Membership in the Illinois State Medical Society?	Yes 51% No 49%	51% 49%	57% 43%
	c. Reappointment to your hospital staff?	Yes 57% No 43%	61% 39%	69% 31%
12.	As an alternative to mandatory participation in a continuing medical education program for membership in the above groups, would you favor periodic examinations conducted by your specialty society or AAGP?	Yes 27% No 73%	39% 61%	38% 62%
13.	The shortage of doctors in medically deprived communities results in heavy caseloads for physicians practicing in these areas. To meet this problem, do you favor:			
	a. Urging resident and intern training facilities to supply manpower to staff health centers—under the direction of a qualified physician—as part of their training programs?	Yes 80% No 20%	67% 33%	74% 26%
	b. ISMS scholarship grants to medical students who agree to practice in ghettos and other deprived areas?	Yes 82% No 18%	78% 22%	80% 20%
	c. Having your state medical society lend financial support to the establishment of health centers in deprived areas?	Yes 56% No 44%	80% 20%	86% 14%
14.	If a community health center were established in a medically deprived area nearby, would you be willing to work there on a:			
	a. Part-time schedule (equivalent of one or two days a month) being reimbursed on a fee-for-service basis?	Yes 64% No 36%	77% 23%	74% 26%
	b. Part-time salaried basis, assuming the salary is agreeable?	Yes 42% No 58%	67% 33%	82% 18%
	c. Part-time schedule, but without reimbursement?	Yes 31% No 69%	43% 57%	66% 34%
	d. Full-time, salaried basis?	Yes 8% No 92%	13% 87%	24% 76%

15. Would you hire a trained and licensed "doctor's assistant" or "feldsher" to work in your office, performing such tasks as preliminary screening for illness, well-baby examination and family planning?	ISMS Members		Residents, Interns Students	
	Yes	39%	67%	75%
	No	61%	33%	25%

COMMENTS

In returning their survey questionnaires, many residents, interns and students included written comments about the questions or the survey in general. Here are a few representative remarks:

On establishment of a state disciplinary board

"Yes, let's get rid of this attitude of no criticism of fellow MDs if they are incompetent or dangerous to patients."—A resident

"Yes, in the long run this would be a great help to the conscientious physician."—A student

On periodic examinations by specialty society or AAGP

"Definitely not!"—A resident

"No, a physician's performance and up-to-date qualifications may be evaluated in several ways, but re-examination is *not* one of them."—A resident

"No. It's traumatic enough to have one's future career hanging in the balance with every exam in medical school."—A student

On a liberalized abortion law

"Yes. Current legal posture as regards abortion is archaic and may be responsible for a great deal of personal suffering as well as incurring heavy public obligation in support of unwanted and/or defective children."—A student

On medical services to deprived areas

"Change the attitude of the medical schools toward the G.P. It's most discouraging to students!"—A resident

"What ghetto medicine needs is a crop of young black doctors willing to go back to the ghetto along with white colleagues and give good medical care full-time. The answer is an increased admission of minority students to medical school."—A student

On physician's assistants

"This could be the type of thing that could bring medical care to a hundred percent of America."—A student

On the survey in general

"I think that by the very fact that you sent this questionnaire to medical students, you have shown some real concern for the future of medical care in this country. To an often disillusioned medical student, this is real progress."—A student

"These issues (in the survey) are for the most part not really the major problems in Illinois health care. More pressing needs exist in the area of health care services to ghetto and rural areas . . . and MDs belonging to minority groups."—A student

"I think this is an excellent survey in that it raises critical issues."—A resident

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fully. If bronchospasm progresses, this medication should be immediately discontinued. **Adverse Effects:** Adverse effects have included stomatitis, nausea and rhinorrhea. Sensitivity and sensitization to Mucomyst have been reported very rarely. A few susceptible patients, particularly asthmatics (see **Warnings**), may experience varying degrees of bronchospasm associated with the administration of nebulized acetylcysteine. Most patients with bronchospasm are quickly relieved by the use of a bronchodilator given by nebulization. **Administration & Dosage:** Mucomyst may be administered by nebulization into a tent, Croupette, face mask, or mouthpiece; or by direct instillation. **Mucomyst should not be placed directly into the chamber of a heated (hot-pot) nebulizer.** Complete details on dosage, administration, and compatibility are included in the package insert. Additional information may be obtained from Mead Johnson Laboratories. **Supplied:** Mucomyst-10 (acetylcysteine), a sterile 10% solution, in vials of 10 ml. and 30 ml.; Mucomyst (acetylcysteine), a sterile 20% solution, in vials of 10 ml. and 30 ml.

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Membership Forum

Excerpts from

An Open Letter to the AMA

December, 1969

A few years ago the AMA conducted an all-out fight against government-dominated medicine. Throughout this battle the constant theme of the AMA was: "political medicine is bad medicine."

I strongly believe this concept was absolutely true at that time. And I believe it is true today. The deterioration in medical care since the advent of "Medicare"; the utter chaos in hospitals; and the further attacks upon the doctors by government agencies—all attest to the truth of the original arguments of the AMA.

Further (and this may be the strongest argument) *principles do not change*. If political meddling in medical care was bad in 1955, then it is bad now.

Yet, in spite of these facts, there is an apparent willingness on the part of many in the AMA to surrender. And to surrender in this case means to completely abandon our principles. If we do surrender to the politicians and socialists, we are saying, in effect, "Yes, political medicine is bad medicine, but in order to placate our enemies, we are willing to see Americans receive inferior medical care. We are willing to practice medicine by government whims and regulations, rather than by our teachings and our medical textbooks: we are willing to forget the precepts of the Hippocratic oath."

The arguments now being proposed are much the same as those of an earlier era. Medical care will be financed by funds from "social security" or—if this is not sufficient—by funds from general taxes. Now what does this mean when translated into ordinary language.

It means that medical care will be "free" to everyone (whether sick or not); those who do not need care will receive it anyway; those who are really ill will be neglected; and the total cost of medical care will be much greater than the cost of private care.

Medicine will deteriorate rapidly. No sincere stu-

dent will want to enter medicine when he knows that, after years of study, he will be the servant of capricious bureaucrats, and that methods of treatment will be dictated by government whim rather than by sound medical principles.

How shall we fight political medicine? How shall we answer our detractors, who have so much control over the news media?

Well, we might start with something very basic and simple. During World War Two, a great fighter named Joe Louis did some exhibition boxing for our troops. A reporter asked him how he felt about serving the Armed Forces of the United States, when he himself was not always well-treated in his own country. This simple man, this great fighter, answered, "There ain't nothing wrong with this country that Mr. Hitler can fix."

We might paraphrase this by saying, "Yes, there are defects in our medical programs, but there ain't nothing that the politicians can fix." In fact, to give the politicians control over American medicine would be akin to appointing Jack the Ripper house mother of a sorority.

No one has the moral right to inflict this system upon the patient or the physician. When we initiate treatment of a patient, there is an implied contract between physician and patient. The doctor agrees to render medical care to that patient. And the patient selects that specific doctor because this is the doctor in whom he has confidence. The patient then pays a fee to the doctor.

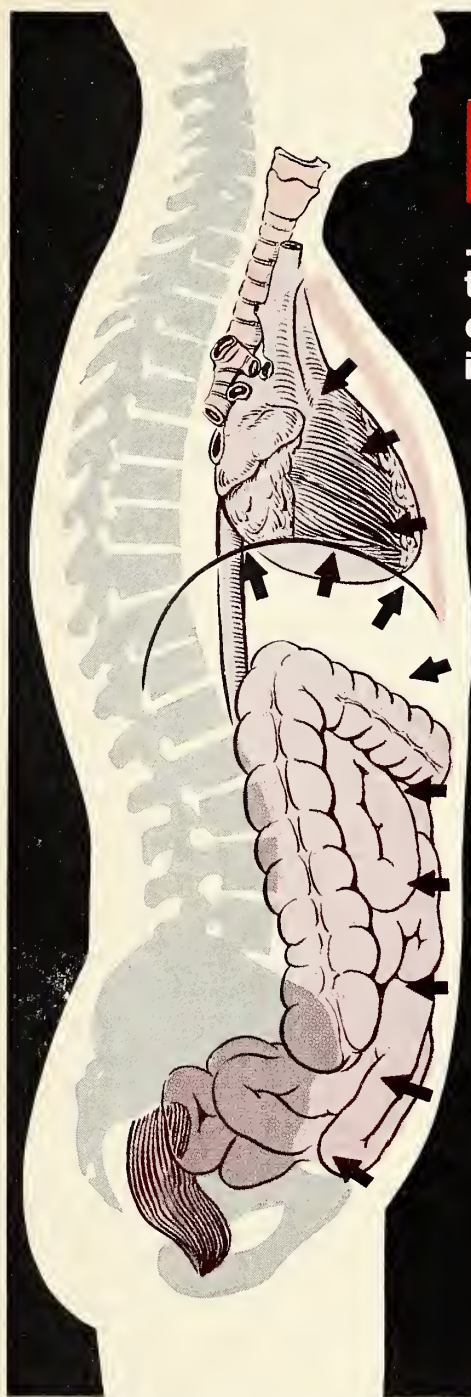
Under the proposed program of government medicine, the patient would not have free choice of physician; the doctor would be told who he might treat (and how he might handle this treatment), the doctor would be paid by a government agency, and the patient would be paying not only for this inevitably inferior care, but also for all the many political employees generated by the program.

As a physician, I am willing to sell my services to the patient who selects me as his doctor. I refuse to sell my services to a government agency. Nor will I accept Wilbur Cohen's earlier idea of "the physician and the government being partners."

Why not propose a choice? Why not make these plans voluntary? One would be under a governmental agency, for those who would choose this type of program. But it must be recognized in advance that this plan will appear to be cheaper than

(Continued on page 176)

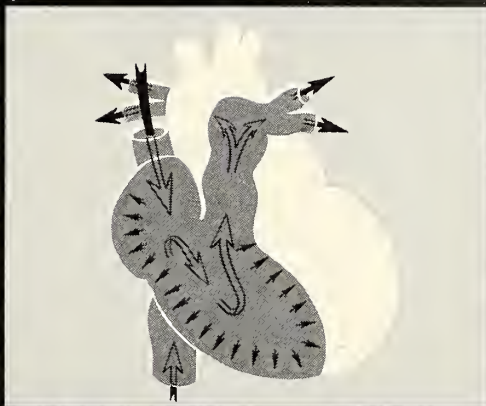
Ed. note: Membership Forum is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.



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Constipation in the chronic heart failure patient carries with it the ever-present threat of acute cardiac decompensation while straining at stool. In the already weakened, distended heart, a sudden influx of blood on termination of the Valsalva maneuver is considered to be the mechanism of some of the deaths occurring in these cardiac patients during straining efforts.*



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Dosage: Adults and children over 12—one or two capsules daily. Children 6 to 12—one capsule daily. Give at bedtime for two or three days or until bowel movements are normal.

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*Best, C. H. and Taylor, N. B.: *The Physiological Basis of Medical Practice*, 7th edition, Williams and Wilkins, Baltimore, 1961, p. 480.

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Rx Products Index

Achrocidin	177	K-Lyte	130-131
Lederle Laboratories		Mead Johnson Laboratories	
Achromycin	119	Librium	128-129
Achrostatin	195	Roche Laboratories	
Lederle Laboratories		Lomotil	2nd Cover
Ambar	120	G. D. Searle & Co.	
A. H. Robins Company		Mellaril	111
Aventyl HCL	114-115	Sandoz Pharmaceuticals	
Eli Lilly and Company		Mucomyst	172-173
Butazolidin	184-185	Mead Johnson Laboratories	
Geigy Pharmaceutical Corp.		Neo-Synephrine (Pediatric)	106
Dicarbosil	194	Winthrop Laboratories	
Arch Laboratories		Obedrin-LA715L	123
Dimetapp	105	Semed Pharmaceuticals	
A. H. Robins Company		Quinamm/AVC	181-182
Donnagel/Robitussin	125-127	National Drug Co.	
A. H. Robins Company		Tepanil	109
Doxidan	175	National Drug Co.	
Hoechst Pharmaceutical Co.		Thera-Combex HP	113
Dyazide	187	Parke Davis & Co.	
Smith, Kline & French Laboratories		Urised	110
Empirin Compound	121	Conal Pharmaceuticals, Inc.	
Burroughs Wellcome & Co.		Vasodilan CVD	116-117
Ilosone	132	Mead Johnson Laboratories	
Eli Lilly and Company		Valium	Back Cover
Isoclor	3rd Cover	Roche Laboratories	
Arnar-Stone Pharmaceuticals, Inc.			

Forum

(Continued from page 174)

any private plan, because it is largely through hidden taxes that the government is able to promulgate its schemes. The individual who purchases such a program should then have the alternative of discontinuing at any time, and transferring to another program if he so wishes.

If there are two programs (the government plan and the continued private practice of medicine), then who will staff the government program?

This staff would be made up of two segments—those private practitioners who now favor government medicine—and the large number of physicians who now staff governmental medical agencies, such as VA, Public Health Hospitals, Military Medical Installations, etc. In other words, if the socialists want government medicine, let them staff the program with government doctors!

The second program would also be *voluntary* and would be based upon the traditional physician-patient relationship. Under this program the patient would continue to have the right to choose his own doctor who, in turn, would not be hamstrung by government regulations in treating his patients. There is no doubt in my mind that, once such a dual system is in effect and the people have had a taste of

the government program, the patients will transfer to the non-government plan in great numbers.

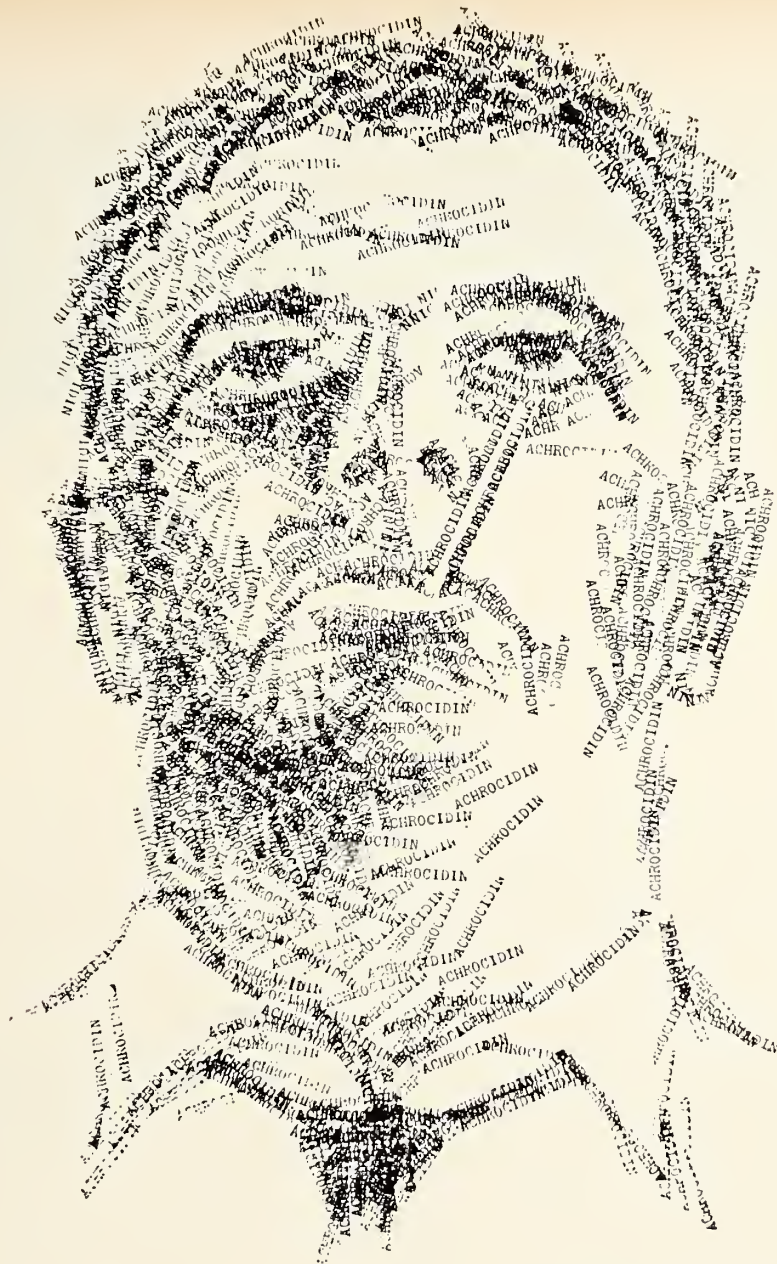
Let those patients who want private medical care utilize this method and permit them to purchase private insurance if they so wish. Let those who are deluded by the idea of "something for nothing" enroll in the government program. Most of them will ultimately return to quality medical care anyway.

Let those physicians who profess to believe in the virtues of a government program become the "government doctors." The profession of medicine will certainly be no poorer for losing them!

And allow those doctors who are sincerely concerned about the welfare of their patients continue to conduct a private system of medical care—while, at the same time, helping to persuade patients on the value of some sort of insurance, and persuading insurance companies that a truly successful insurance program will provide for underwriting ALL patients, regardless of past history.

As professional men, as doctors who are deeply concerned for the welfare of our patients, as loyal Americans—we MUST say "NO" to socialized medicine.

Sincerely,
Max Klinghoffer, M.D.



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ACHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatment of tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of the upper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons

on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculo-

popular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.



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Educate, Don't Vegetate

BY JANET KRUMM/LAKE COUNTY

The Illinois Medical Assistants Association held their Annual Educational Symposium on September 21, 1969. DeKalb County was host to 74 members representing 12 county chapters: Cook-Chicago, Cook-Northwest, DeKalb, DuPage, Kane, Lake, McHenry, McLean, Sangamon, St. Clair, Vermilion and Will-Grundy. The advisors present were Dr. Anna E. Barnstable, Dr. Allison Burdick, Dr. Lloyd F. Walk and Dr. John L. Wright.

The theme for the day was "Educate, Don't Vegetate." The group welcomed Alice Burge, president, DeKalb Medical Assistants Association, Zelma Bechtol, president, the Illinois Medical Assistants Association, and Dr. Wilbur Thompson, president-elect, DeKalb County Medical Society. Dr. Carl E. Clark, Illinois State Medical Society liaison to the IMAA Advisory Committee, was moderator for a panel discussion on "Socio-Medical Problems of Our Times."

The first speaker was a representative from Alcoholics Anonymous. He spoke from experience and discussed the type of person who needs AA. His wife talked about the Purpose of Alanon which is an organization for family or friends of an alcoholic.

The next facet of the panel was Show & Tell, by Detective Lt. Salomi and his partner from the DeKalb County Police Department. He showed pictures and samples

of the marijuana plant and items confiscated in household raids such as a pillowcase full of marijuana that was dried in a clothes dryer and a coffee mill used for grinding. A synthetic sample of marijuana was burned for those in the audience unfamiliar with the odor.

The panel discussion was concluded by a talk on Medical Health Problems in Family Practice by Irving Frank, M.D.

"On Guard" by Mr. Joseph C. Kunches, general agent, Medical Protective Company, St. Charles, opened the afternoon session. He stressed procedures that the medical assistant should use to prevent liability claims against her doctor, or others in the medical profession.

The closing speaker was Trooper W. S. Smith, Rock Island, who has been with the Illinois State Police Department for 13 years. His topic "Behind the Wheels" was about the different types of traffic accidents and some of the basic rules for avoiding them. He recommended that drivers take a Defensive Driving Course because of faster and more numerous automobiles.

If your medical assistant is interested in benefiting from our educational programs, please contact either Mrs. Vivian Johnson, first vice-president, 9105 S. Albany, Evergreen Park, 60642 or Mrs. Mary Siers, second vice-president, 801 North 84th Street, East St. Louis, 62203.

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

By JOSEPH J. LOTHARIUS

Medicare Explains More Than Allowable Charge

When an MD's charge for a service is more than the amount which can be allowed under the Medicare program, the explanation of medicare benefits will show "More Than the Allowable Charge." This wording is prescribed by the Bureau of Health Insurance for all Part B carriers throughout the country. It is not intended to imply that the MD has charged more than should have been charged, nor that this service to the patient is worth less than the amount charged. Under the Medicare law there are limits on the benefits which can be allowed. It is recognized that the physician may provide services which are worth more than the allowable benefit.

+++++

MD Agrees to Payment When Accepting Assignment

In accepting an assignment under Medicare, the MD agrees to accept the carrier's allowable charge determination as his full charge. The patient is still responsible to pay the deductible, if any, and the co-insurance. However, the patient may not be billed for any amount of the physician's charge in excess of the allowable.

EXAMPLE:

MD's charge	\$600
Allowable	\$550
Less Unsatisfied Deductible	\$ 50
Balance	\$500
Medicare Pays	
(80% of balance)	\$400

The MD may collect the amount of the deductible (\$50) plus coinsurance (\$100), a total of \$150 from the patient. However, he cannot collect the additional \$50 by which his charge exceeded the allowable determination.

(Reprinted from Prudential Medicare Bulletin)

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MDs Asked To Certify Medicaid Claims

Effective April 1, 1970, physicians will be asked to certify the truth and accuracy of their medicaid claims, according to a policy notice from HEW's Social and Rehabilitation Service that appeared in the *Federal Register*. The following statement will be imprinted in bold face type on all

provider claim forms above the claimant's signature: "This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material fact, may be prosecuted under applicable Federal or State Laws."

Patients Can OK Use of Hospital Records

Illinois House Bill 1084, recently signed by Governor Ogilvie, enables patients to authorize the release of their hospital records. The bill provides that following the patient's release from a hospital, he can permit his physician or attorney to examine all records kept in connection with the treatment he received and permit copies of such records to be made. According to the bill, the patient's demand must be in writing and does not apply to records relating to psychiatric care.

New Laws Signed Affect Treatment of Minors

Several new bills signed into law affect the medical treatment for minors in Illinois. These bills include: House Bill 139—minors 18 years or older can give binding legal consent to medical and surgical procedures; House Bill 140—makes unnecessary the obtaining of consent by physician or hospital before rendering emergency treatment to a minor; Senate Bill 777 allows a minor, 18 years or older, to donate blood without having parental consent; Senate Bill 550 permits a minor, 12 years or older, to give binding consent to medical treatment for venereal disease; Senate Bill 549 provides that a local health department or school district must pay for required immunizations if the parent or guardian is unable to do so; House Bill 2732 authorizes MDs to supervise and control the rendering of birth control services and information to "certain minors."

YOUR INSURANCE QUESTIONS

QUESTION: I already have a Keogh plan. Now I would like to incorporate. What can I do with my Keogh plan?

ANSWER: You have two basic choices. Withdraw the money from the Keogh plan and pay the penalty, which is not severe. It is 110 per cent of the tax applied over five years, or the number of years that the plan has been in effect if less than five. That amounts to 10 per cent extra tax. The second choice is to leave the money in the Keogh plan. It will grow and add to your retirement income.

Do you have a question of general interest on any ISMS-sponsored insurance program: Retirement Investment, Keogh, Group Disability, Group Major Medical, Professional Liability (Malpractice)? Send it to this column: "Your ISMS Insurance Questions," Illinois Medical Journal, 360 N. Michigan Avenue, Chicago, Ill. 60601. The column is a service of the ISMS Committee on Insurance.

Meeting Memos

Every Tuesday—Chest Conference

4-5 p.m. Chicago State T.B. Sanitarium
1919 W. Taylor St., Chicago

Feb. 25-26—The Cleveland Clinic Educational Foundation

Postgraduate Course
2020 East 93rd St., Cleveland, Ohio
"Selected Topics in Basic and Clinical Immunology"

Feb. 25-March 1—The American College of Cardiology

19th Annual Scientific Session
The Rivergate Center, New Orleans, La.

March 4—Mt. Sinai Hospital and Medical Center

Combined meeting
Chicago Medical School
Chicago Urological Society
Kling Auditorium, Mt. Sinai Hospital Medical Center

2-4:30 p.m.

"The Physician in the World of the 70s"
Dinner Speaker—Sen. Ralph Smith

March 6—Chicago Surgical Society

Scientific Program
76 E. Monroe St., Chicago

March 10-14—International Academy of Pathology

59th Annual Meeting
Chase-Park Plaza Hotel
St. Louis, Missouri

March 11—Frontiers of Medicine Series University of Chicago

Gout and Purine Metabolism
Center For Continuing Education
1307 East 60th St., Chicago

March 11-12—The Cleveland Clinic Educational Foundation

Postgraduate Course
2020 East 93rd St., Cleveland, Ohio
"Current Management of Common Orthopaedic Problems"

March 12—The Institute of Medicine of Chicago

Forum on Health Topics
Gold Room, Lawson YMCA, Chicago
"What You Should Know About Your Heart"

March 12-14—University of Wisconsin Department of Pediatrics

Conference
University of Wisconsin Medical School Madison, Wisconsin
"Infectious Diseases"

March 13-15—American Psychiatric Association

9th Colloquium For Postgraduate Teaching of Psychiatry
Sheraton Motor Inn, Portland, Ore.

March 15-19—The American Society of Anesthesiologists

44th Congress—International Anesthesia Research
Caesar's Palace, Las Vegas, Nevada

March 16-27—The American College of Cardiology

Phonocardiography
The Chicago Medical School
2020 W. Ogden Ave., Chicago

March 16-18—The American College of Surgeons

Doctors-Nurses Joint Meeting
Sheraton Park Hotel, Washington, D.C.

March 16-18—American Academy of Orthopaedic Surgeons

Postgraduate Course
Chicago
"Orthopaedic Rehabilitation"

March 18-20—University of Kentucky College of Medicine

Advanced Hematology Techniques
&
Head and Neck Disorders in Children
Albert B. Chandler Medical Center
University of Kentucky, Lexington, Ky.

March 18—University of Chicago Section of Ophthalmology

Annual Alumni Day
Albert Merritt Billings Hospital
Chicago

THE CHALLENGE OF TUBERCULOSIS

Much of the tuberculosis of former years occurred in adolescents and young adults and represented relatively early development of disease following implantation of infection. Now most of the cases occur in older persons who were never aware of being infected and who have had no recent contact with the disease. These cases arise through late progression of long-dormant infections and offer quite a new challenge to today's physician. (William W. Stead: *The New Face of Tuberculosis*, **Hospital Practice** [Oct.] 1969.)



Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alkali formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastro-

intestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be

closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative derma-

in cardiac edema

Dyazide[®] Trademark

Each capsule contains 50 mg. of Dyrenium[®] (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported, in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium and BUN during therapy, particularly in patients with suspected or confirmed renal or hepatic insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—their combined use can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to

cross the placental barrier and appear in breast milk; thus adverse reactions which have occurred in adults may occur in the fetus or newborn infant. Rarely, thrombocytopenia or pancreatitis has developed in newborn infants whose mothers had received thiazides during pregnancy. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte determinations. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Adjust dose of antihypertensive agents given concomitantly.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, altered carbohydrate metabolism, hyperbilirubinemia, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

SK
&F

Smith Kline & French Laboratories

The Growth of

Forensic Pathology In Illinois

BY EDWIN F. HIRSCH, M.D., PH.D./CHICAGO

General and special pathology are the basic principles for those prevailing in the field of forensic pathology. The beginnings of forensic pathology in Illinois can be traced to several physicians who, interested in the morbid changes produced by disease in the human body, during the days of primitive medicine in Chicago examined the bodies of those deceased at the Cook County Hospital in order to correlate clinical symptoms with visceral disorders.

Henry M. Lyman (1863), Hosmer A. Johnson (1870) and I. N. Danforth (1877) comprised this group. Danforth is the only one who should be considered a pathologist. His first lecture to the students after his appointment as attending pathologist April 28, 1877, was on "The Relation of the Post-mortem to Medico-Legal Evidence." An upheaval at the County Hospital in 1878 disrupted the medical staff and dislodged the pathologist.

Dr. Christian Fenger

Christian Fenger, a Danish physician, remarkably well trained in pathology and surgery, arrived in Chicago during the summer of 1877. He then was 37 years of age, and in the spring of 1878 secured by means of a fee, an appointment as physician at the Cook County Hospital. There he gave lectures and demonstrations in pathology, a science then unknown to the attending

staff. The following year Fenger substituted for the surgeons while they were away on vacations. He served on the medical staff of the County Hospital for about 14 years, first as a pathologist and later as a surgeon, and in surgery introduced the antiseptic technic devised by Lord Lister.

The concurrence of the times and the circumstances then prevailing in Chicago gave Fenger the opportunity to apply his personality and superb training so that shortly he became a dynamic leader in medicine, here and nationally. What were the characteristics in Christian Fenger's personality that enabled him to give to medicine and to pathology so much in so short a time (1877-1902)? James B. Herrick recorded these significant comments in answer to this query.

"From Christian Fenger emanated something that is difficult to express in one word. Was it not largely humility, effacement of self, a sincere effort to work not for the sake of personal glory, but to help the other man? Reward for Fenger came not in a reputation for brilliancy as an operator or a teacher. His reward was in the respect and affection of the student who recognized that the master was giving of his best to help another. His life was proof that it is more blessed to give than to receive. Dr. Fenger's glory is that he made to medical Chicago and the Northwest, the gift of a group of physicians whom he activated to a modern conception of pathology, to more scientific ways of think-

This lecture was presented to the International College of Surgeons, Chicago, on Nov. 21, 1967.

ing, to a form of practice in which the standard of success is intellectual honesty, rather than financial return or reputation as a brilliant teacher or operator. The transmitted influence of this group, the Fenger School, is still at work. It will never die."

Christian Fenger taught and practiced medicine in Chicago for 25 years. At the age of 62 he was stricken with pneumonia and died on March 7, 1902.

The names of men of the Fenger School include pioneer leaders of Chicago Medicine such as Frank Billings, Ludvig Hektoen, James B. Herrick, E. R. LeCount, Henry Baird Favill, Howard Taylor Ricketts, H. Gideon Wells, Lewis L. McArthur, and others—what a progeny.

County Coroners

The list of the Cook County coroners and their terms of service since the institution of this Constitutional office in April, 1831, includes several physicians. Dr. Ernst Schmidt, the father of two outstanding physicians in Chicago, Otto and Louis, served from November, 1862, to January, 1864. Henry L. Herz, a layman, during his term in office, December, 1884, to December, 1892, initiated on March 1, 1890, the use of a pathologist for the medical investigation and examination of cases referred to the coroner of Cook County when he appointed Dr. Ludvig Hektoen as a deputy coroner.

Peter M. Hoffman became coroner of Cook County in December, 1904, and served continuously in the office for 18 years, ending December, 1922. The principle of appointing physicians as deputy coroners for the medical examination and investigation of cases referred to the office

was in effect, but for reasons not entirely clear, the deputies appointed at this time, although licensed physicians, were not pathologists. This practice veered in the direction of political patronage. In 1911, during the Hoffman regimen, Doctor E. R. LeCount, professor of pathology at Rush Medical College, was appointed chief deputy coroner, and presently was stationed for his postmortem examinations at the morgue of Cook County Hospital. LeCount was meticulous. He compiled in successive daybooks, the date of examination, the name of the deceased, the cause of death, and the name of the student assistant who completed the record. I have these daybooks through his entire service as chief coroner's physician. On the front page of the first daybook, written in long-hand and with his signature is the following: "My work as Coroner's Physician began July 15, 1911, but this daybook was not begun until September 11, 1911, nearly two months later." Then followed this comment, "This daybook of the work of one of the Coroner's Physicians of the County of Cook, Illinois, is of no value to anyone but him and if found should be returned to him at Rush Medical College or at 6026 Kenwood Avenue, Chicago." This statement appears on the front page of each daybook and the record ends August 21, 1924, after 13 years. LeCount ranked among the outstanding forensic pathologists in this country.

Strict Discipline Maintained

Two medical students at Rush assisted LeCount in the coroner's morgue with the necropsies and the records. The disciplines were strict. No gossip conversation was permitted and nothing about the necropsies was to be mentioned to outsiders. The student service appointment was for three months without a break, and no classes at Rush until after 11 a.m. Work in the morgue for the students began before 7 a.m., pushed up to 6 a.m. The external descriptions of the bodies including anatomic charts of external injuries and other items were completed before the "Duke" arrived.

I had entered upon a program of teaching and research in the Department of Pathology at the University of Chicago under H. Gideon Wells. The junior and senior years of clinical medicine at that time were

Edwin F. Hirsch, M.D., is a Chicago pathologist. He received his M.D. degree from Rush Medical College, and his Ph.D. degree in pathology from the University of Illinois. In addition, Dr. Hirsch is a member of the American Society for Clinical Investigation, American Association of Pathologists and Bacteriologists, International Academy of Pathology and the College of American Pathologists.



given on the West Side at Rush Medical College and the Presbyterian Hospital. My first quarter on the West Side was in the summer of 1913. Dr. Wells suggested that I approach LeCount for an appointment as a student assistant in the morgue during the fall quarter, then return to the Midway for the winter quarter. I went to LeCount's office as directed and stated my purpose. LeCount promptly dismissed me with the comment that he knew of no good reason why he should train any of Wells' men. But shortly afterward, in the evening, I received a telephone call from John Nuzum, a student assistant, to report at the coroner's morgue the next morning, a Sunday, at 9 o'clock. I arrived at the place designated promptly at 9 a.m., just as LeCount was leaving. He greeted me with the admonition, "You were supposed to be here at 7 o'clock." After this misunderstanding in timing had been clarified, a preceptor-student relationship began that continued until his death in the summer of 1935, and in fulfillment of his instructions to me, through the postmortem examination of his body.

Politics Take Over

Oscar Wolff became coroner in December, 1922. LeCount continued as chief coroner's physician until August 21, 1924. According to rumor, the doctor was dismissed for reasons of political expediency. Wolff was succeeded December, 1928, by Dr. Herman N. Bundesen. Bundesen had resigned from his position as Commissioner in the Department of Health of Chicago and was elected coroner for the purpose of restoring the quality of the medical examinations which had prevailed under LeCount. Friction among members of a Coroners' Advisory Committee thwarted the effort and Bundesen resigned November 17, 1931. The appointment of coroners' physicians then reverted to a political spoils system.

The medical examinations for the coroner at the morgue of the Cook County Hospital then for a time were conducted by Samuel A. Levinson, Jerry J. Kearns, and others, handicapped because of the meager equipment and the limited facilities for toxicological examinations. They carried on in the hope that a new dawn would revive the quality of the medical examina-

tions in the coroner's office of Cook County.

Committees Go To Work

For many years, prior to 1952, committees of the Institute of Medicine of Chicago, with Oscar T. Schultz as chairman, advocated improvements in the quality of the medical examinations of deaths referred to the coroner of Cook County for investigation. This committee proposed the replacement of the coroner system by the so-called medical examiner system, in which among other provisions, pathologists with training in forensic pathology would investigate the cases referred to the coroner. This proposal is not simple because the coroner's office is a provision of the Constitution, and its abolishment requires a referendum vote. Little was accomplished until Dr. F. Lee Stone on May 1, 1952, introduced into the Council of the Chicago Medical Society a resolution urging the modernization of the medical examinations of the cases referred to the coroners of the 102 counties in the State of Illinois. The Council of the Chicago Medical Society acted favorably on the resolution and soon thereafter it was adopted by the House of Delegates of the Illinois State Medical Society.

A committee was appointed for the purposes of the resolution by the State Medical Society. Mutual interests then brought together for discussions, this committee of the Illinois Medical Society and officers of the Illinois Coroners' Association. These meetings established mutual trust and confidence with the decision to join in efforts toward achieving improvements in the coroner's functions by suitable legislation. The 69th General Assembly in 1955 established an Advisory Board on Necropsy Services to Coroners in the State Department of Public Health. This board of nine members, appointed by the Governor, consists of three physicians, at least two of them pathologists, three elected coroners, and three not physicians nor coroners, but interested in forensic medicine. The organizational meeting of the board at Springfield, January 18, 1957, immediately motivated a program for new legislation. The board recommended to the 70th General Assembly, then in session, a bill extensively revising the duties of the county

coroners, sponsored jointly by the Illinois Coroners' Association and the Illinois State Medical Society. This bill was passed and became a part of the Illinois statutes.

Milestone Reached

A letter later in the year, from O. K. Sagen of the U.S. Public Health Service, made these significant comments: "The enactment of this legislation is a real milestone in Illinois' progress. In particular, I wish to express my appreciation to the Advisory Board for the fine work it has done in such a short time toward getting the Illinois Coroners' Act modernized and preparing the ground for the operation of the new system.

"It is my belief that the revised medico-legal system in Illinois points the way for the entire country, and that the Illinois accomplishments . . . will be the object of nationwide scrutiny. By taking the best features of the ancient coroner system and welding them with some of the better features of the medical examiner system, we can look forward to a practical, enlightened operation of a medico-legal system.

"In the new Illinois system almost everything depends on how well your Advisory Board can do its job. If you can develop a good practical procedure which the coroners can use and be prepared to offer them the technical advice they need, then I am sure the system will work out very well."

Important activities of the Advisory Board resulted in the publication of manuals of instruction for the coroners' physicians, for the guidance of the coroner in the conduct of his office, and in the 71st General Assembly the passage of a bill providing laboratories for toxicological examinations for the coroners and for other purposes. One of these laboratories for the northern tier of the counties has been established in the Branch Laboratory of the Public Health Department in Chicago. Another is contemplated for the southern tier of counties in Springfield.

The Coroners' Bill, passed in 1957, specified that wherever possible the necropsies for the coroners should be made by pathologists. The coroners of the 101 downstate counties have recommended the appointment of many pathologists who practice in their local communities. These physi-

cians conduct the medical examinations of cases referred to the elected coroner of a county for investigation.

Benefits Enumerated

The benefits of these activities were reflected into Chicago and Cook County. The original Cook County Morgue Building at the County Hospital was assigned to the purposes of the coroner for reconstruction by the County Board. The funds for this were provided by the board and a voted bond issue. The initial phase of revision effected a complete rebuilding of the first floor for inquests and of the basement area for autopsy facilities and crypts for the storage of bodies. Nine refrigerated, ceramic tile-lined, walk-in crypts modernized the body storage facilities. They have a capacity for about 200 bodies, a provision against disaster situations. Three separate fully equipped and well-lighted necropsy rooms, also ceramic tile-lined, each with two necropsy tables, and another necropsy room with one table for the examination of decomposed bodies, were installed in proximate relationship with the crypts for storage purposes. X-ray equipment and radiolucent mortuary trays add to the improved facilities. The entire first floor was rebuilt for inquests, offices, and other purposes.

Another phase in the reconstruction of the county morgue has removed the old amphitheater. The second and third floors are in the process of being rebuilt. The third floor eventually will be equipped for toxicology; the second for pathology and related functions.

The procurement of professional and other trained personnel to develop the functional services of these reconstructed facilities is a pressing issue. The coordination of these functions with the police, the crime detection laboratory, the funeral directors, the physicians, and especially the community is a complex operation. Progress has been made, as one must realize by these statements, and more will follow. Dr. Andrew J. Toman, the present Coroner of Cook County, has vigorously supported the development of this program. The progress made in the State of Illinois, as outlined, has attracted the attention of other groups throughout the country. The work load of medical investigations delegated to

the county coroners in Illinois is reflected by these statistics. Of 109,448 deaths in the State in 1966, approximately one-half of them in Cook County, every fifth death was referred to coroners for investigation.

The potentials for developing in Cook County and throughout the State an outstanding system for the medical investigation of deaths referred to coroners have never been as favorable.

Curiosity, observation and an imaginative faculty for correlating facts, besides his personality, are desired assets in a forensic pathologist. He continually is faced with determining by his investigations of sudden unexpected death, those due to natural causes and those due to unnatural. Negative findings can be as important as the positive. LeCount, during my initial training with him, was confronted with the death of a young Italian woman, caused by an acute meningitis. The cranial sinuses and the middle ears provided no clues about the source of this infection. When the dura was stripped from the base of the cranium, a focus of osteomyelitis was exposed anteriorly in the left half of the middle cranial fossa. Then the skin over the left malar prominence of the face was found to have a thin horizontal scar whose shape and appearance resembled a healed stab (stiletto) wound. These facts directed the investigation from a death due to a natural cause to one that was homicidal.

Direct examinations with conclusions, such as this, are simple. Others are much more complex and require chemical analyses and tissue techniques. Laboratories equipped for these purposes in the coroner's organization, in the past, were limited. They are now in the process of develop-

ment in the Institute of Forensic Pathology for the coroner on the West Side.

The Goal

The crime detection laboratory of the Chicago Police Department is described in a recent series by a Chicago newspaper as the best in the United States. The goal in rebuilding the Coroner's Institute of Forensic Pathology is to develop its organization to a similar level of excellency in the quality of the medical examinations referred for investigation and to achieve scientific coordination with the Crime Laboratory of the Chicago Police Department in the solution of, or the prevention of, homicides.

The tediums of slow or of little progress arouse feelings of frustration. Although considerable progress has been achieved, much more needs to be done in order to reach the goal. Medicine and community leaders should face the issues of this important service with confidence and vigor. ◀

Ed. note:

In the present State Constitution, the only medically connected reference pertains to the Coroner System. At present, the Constitution requires that coroners be elected in every county.

Of a recent survey of Illinois physicians, conducted by the Illinois State Medical Society, Division of Legislation and Public Affairs, over 750 responded in the following manner: Those physicians favoring retention of the present Coroner System numbered a mere 63 of the total. A combination Board of Medical Examiners and Coroner System received 100 votes, while the overwhelming majority of 553 preferred to abolish the present system and establish a system of medical examiners.

Regardless of these statistics on physicians' attitudes, the Coroner system will undoubtedly prove to be one of the most hotly contested issues of the current Constitutional Convention.

Your March *IMJ* will carry an article on Future Forensic Medicine in Illinois.

Cardiac Pulsator Developed

A relatively simple device developed at The University of Chicago can keep a cadaver heart pumping blood to preserve other organs for possible transplants.

The cardiac pulsator—consisting of an air compressor with an attached rubber tube and bulb leading to a clear plastic shell which surrounds the heart—would allow time for careful tissue typing while maintaining a normal blood supply to the needed organ.

The first clinical use of the device, however, will be in emergency room and surgical situations to attempt to restore normal heartbeat when all other means of saving a failing heart have failed.

According to Dr. Vladimir Kocandrl, instructor and trainee in surgery in the University's Pritzker School of Medicine, this first clinical use of the device for emergency situations will be made in the near future in the University's Hospitals and Clinics.

NEW

PHARMACEUTICAL SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

DUPLICATE PRODUCTS

CETAMIDE OPHTHALMIC

OINTMENT 10% Eye Preparation R

Manufacturer: Alcon

Nonproprietary Name: Sodium Sulfacetamide.

Indications: Conjunctival infection, especially following foreign body removal and other appropriate operative procedures.

Contraindications: Sulfonamide sensitivity

Dosage: Small amount of ointment in conjunctival sac and along lash margins 3 times a day.

Supplied: Tube—3.5 gm.

DIHYDROTACHYSTEROL

Hormones-Calcium R

Manufacturer: Philips Roxane

Nonproprietary Name: Dihydrotachysterol

Indications: Hypocalcemia associated with hypoparathyroidism.

Contraindications: Hypercalcemia and hypocalcemia associated with renal insufficiency and hyperphosphatemia.

Dosage: Initial: 0.8 mg.—2.4 mg. daily for several days. Maintenance: 0.2 mg.—1.8 mg. weekly as required for normal serum calcium level.

Supplied: Tablets—0.2 mg.

RUBELLA VIRUS

VACCINE, LIVE Biological R

Manufacturer: Philips Roxane

Nonproprietary Name: Rubella virus vaccine, live.

Indications: Immunization against German measles.

Contraindications: Do not administer to pregnant women. Sensitivity to neomycin, dogs or dog dander. Febrile illness, leukemia, lymphoma, generalized malignancy or lowered resistance due to therapy with corticosteroids, alkylating drugs, antimetabolites or radiation. Separate vaccination at least one month from administration of other live virus vaccines.

Dosage: Injection, i.m. or s.c.—0.5 cc.

Supplied: Vials

ULTRA TEARS Eye Preparation o-t-c

Manufacturer: Alcon

Nonproprietary Name: Hydroxypropyl Methylcellulose

Indications: For lubrication in tear deficient patients as in keratoconjunctivitis, sicca and for gonioscopic work.

Contraindications: None mentioned.

Dosage: One or two drops topically in eyes three times daily.

Supplied: Drop-tainer Dispenser—15 cc.

COMBINATION PRODUCT

HISTABID Cold Preparation R

Manufacturer: Meyer

Composition: Chlorpheniramine Maleate 8.0 mg.

Phenylpropanolamine HCl 35.0 mg.

Phenylephrine HCl 15.0 mg.

Indications: Symptomatic relief of upper respiratory tract infections and allergies.

Contraindications: Hypersensitivity to any of the components.

Dosage: Adults and children over 6: 1 capsule on arising and 1 twelve hours later.

Supplied: Capsules

ISOPTO HOMATROPINE Eye Preparation R

Manufacturer: Alcon

Composition:

Homatropine Hydrobromide (2.0% or 5.0%)

Hydroxypropyl Methylcellulose 0.5%

Indications: Mydriasis, cycloplegia, cycloplegic refraction and inflammatory conditions of the uveal tract.

Contraindications: Glaucoma and hypersensitivity to belladonna alkaloids.

Dosage: Refraction: 1 or 2 drops topically in the eyes repeated 2 to 3 times at 5-10 minute intervals.

Therapy: 1 or 2 drops topically every 3-4 hrs.

Supplied: Drop-tainer Dispenser—5 cc.

NATABEC Kapseals Vitamins w/minerals R

Manufacturer: Parke, Davis

Composition: Vitamin A 1.2 mg. (4000 units)

Vitamin D 10.0 mcg. (400 units)

Vitamin C 50.0 mg.

Vitamin B₁ 3.0 mg.

Vitamin B₂ 2.0 mg.

Vitamin B₆ 3.0 mg.

Vitamin B₁₂ 5.0 mcg.

Nicotinamide 10.0 mg.

Folic acid 1.0 mg.

Calcium

Carbonate 600.0 mg.

Ferrous

Sulfate 150.0 mg.

Indications: Vitamin and mineral supplement for use during pregnancy and lactation.

Contraindications: None mentioned

Dosage: 1 capsule daily

Supplied: Capsules

PROBEC-T Vitamins o-t-c

Manufacturer: Stuart

Composition: Each tablet contains:

Ascorbic Acid 600 mg.

Thiamine Mononitrate 15 mg.

Riboflavin 10 mg.

Pyridoxine HCl 5 mg.

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Calcium Pantothenate 20 mg.

Indications: Conditions requiring adjunctive nutritional supplementation with B-complex vitamins and Vitamin C.

Contraindications: None mentioned

Dosage: One tablet with meal—higher doses when needed.

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NEW DOSAGE FORMS

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Manufacturer: Lilly

Nonproprietary Name: Flurandrenolone (tape)

Indications: Adjunctive therapy of chronic re-

(Continued on page 194)

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SPECIALTY REVIEW COURSE IN MEDICINE, Part II, March 2
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BASIC INTERNAL MEDICINE, One Week, April 6
GENERAL PRACTICE REVIEW, One Week, April 27
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The University

(Continued from page 137)

Ed.'s Note: On January 9, 1970, the reorganization described in this paper took place. The college of Medicine established a School of Basic Medical Science and the Abraham Lincoln School of Medicine, both at the Medical Center Campus of the University, in Chicago. Former Dean William J. Grove became Executive Dean of the College, and Alexander M. Schmidt was appointed Dean of the Abraham Lincoln School of Medicine. Plans for the establishment of a School of Basic Medical Science at Urbana, Illinois, and clinical schools at Peoria and Rockford, Illinois, are progressing rapidly.

References

1. Paddock, W., et al; FAMINE—1975. Little Brown and Company, Boston, Mass., 1967.
2. Young, G., "Dry Land and a Hungry World," Trans. New York Academy of Science, 1969.
3. Gould, S. B., "The Modern University: Concerns for the Future," *Science*, 155: 24 March 1967.
4. Weinerman, E. R., "Academic Medicine: Providing a Full Spectrum of Care," *Science*, 10 May 1968.

New Pharmaceutical Specialties

(Continued from page 193)

calitrant dermatoses responsive to topical corticosteroids, particularly dry, scaling localized lesions.

Contraindications: Chickenpox, vaccinia, patients with a hypersensitivity to its components, lesions exuding serum or intertriginous areas.

Dosage: Apply to required area-including a quarter-inch margin of normal skin. Replace in 12 hours.

Supplied: Rolls—7.5 cm. x 200 cm.—4 mcg./sq. cm.

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THE VIEW BOX

(Continued from page 157)

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4. Encapsulated areas of effusion on the basis of cardiac decompensation

The fluid when it encapsulates in fissures has an elliptical appearance. On the PA chest we have an encapsulation in the minor fissure on the right and a second encapsulation which is best demonstrated on the tomogram in the accessory fissure. These are recognized as encapsulated effusions because of their shape which is elliptical as a result of distension of the pleural space by the encapsulated fluid. You will also note a small amount of sublamellar effusion along the right lateral chest wall which is one of the hallmarks of congestive failure. These are so-called "vanishing tumors" which readily cleared when the patient was placed on diuretics and digitalis therapy.

Reference

Felson, Benjamin; FUNDAMENTALS OF CHEST ROENTGENOLOGY, W. B. Saunders Company, Philadelphia, pp. 195-200, June, 1964.

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"The businessman personally, as a citizen deplores crime. He often lives and usually works in the city. What does it avail him—or anyone in fact—to build a career and an income if he must live in fear of becoming a crime victim. Money is no good if you live in a jungle."—Richard L. Gelb, president, Bristol-Myers Company.

Fasten Your Seat Belts—Tighter

A new quarterly survey by the Census Bureau reveals: There were 70 million cars in use last July, an increase of four million in a year's time. Households with more than one car increased from 27 to 29 per cent.

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ABSTRACTS OF BOARD ACTIONS 225

CLINICAL ARTICLES

Clinical Cancer Chemotherapy Aimed at Cellular Control Mechanisms
Frances E. Knock, M.D., Ph.D., et al. 229
 Experience in Suicide Prevention
James L. Wilkins, Ph.D. 257
 Morbidity Patterns Reflected in a School Health Program During an Influenza Epidemic Season
Domingo Dominic Leonida, M.D., M.P.H. 262
 Response of Staphylococcal Respiratory Infections to Dicloxacillin
Lester A. Nathan, M.D. 290

SURGICAL GRAND ROUNDS

Pasteurella Multocida 247

SPECIAL ARTICLES

Our Responsibilities
Paul C. Bucy, M.D. 239
 Future Forensic Medicine in Illinois
Samuel K. Lewis, M.D. 253
 Peer Review Guidelines 265

FEATURES

The President's Page 209
 The View Box 238
 Editorials 245
 The Doctor's Library 256
 Membership Forum 271
 Clinics for Crippled Children 280
 Meeting Memos 281
 Socio-Economic News 283
 Illinois Medical Assistants Association 285
 New Pharmaceutical Specialties 286
 Physicians Placement Service 289
 Obituaries 292

(Cover story on page 214)

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Vol. 4, No. 3

March, 1970

Peer Review Gains Momentum

The Illinois State Medical Society announced a new state-wide mechanism of Peer Review to evaluate the quality and cost of modern medical care at its 1970 Leadership Conference, February 8, in Chicago.

More than 250 medical society leaders from Illinois attended the conference to learn how to broaden and strengthen Peer Review.

Dr. Frank J. Jirka, Jr., Chairman of the Illinois State Medical Society Board of Trustees, explained that "with the cost of medical care rising at an unprecedented rate, the medical profession must do all in its power to insure patients the highest quality of care at the most moderate cost."

Dr. John C. Troxel, Senior Vice President, Medical Director, Blue Cross and Blue Shield Plan of Illinois Medical Service, participated in the program and assured representatives of the Illinois State Medical Society that Illinois Blue Shield will do what it can to assist Peer Review committees and to provide them all information which does not involve a breach of confidence. Blue Shield's experience in processing claims for health care has resulted in an accumulation of data which can be used to identify patterns of practice that may be of assistance to a Peer Review committee.

The Board of Trustees of the Blue Shield Plan joins the Illinois State Medical Society in offering assistance to broaden and strengthen the Peer Review system whenever it can.

Objectives of the Peer Review program explained by Dr. Jirka, are to:

1. Conserve the patients' health care dollar;
2. Assure appropriate use of health care personnel and facilities; and
3. Maintain the high standards of medical practice.

To accomplish this, Illinois physicians will establish Peer Review committees comprised of Specialists and General Practitioners on a county, district, and state level to review matters relating to the objectives above, submitted by physicians, government agencies, private voluntary agencies, and patients.

Dr. Troxel stated that Blue Shield is not only concerned with effective Peer Review because it's the largest purchaser of health care in Illinois—3,000,000 Blue Cross members, 2,500,000 Blue Shield members, 25% of the Illinois population—

but, also if the health care system as we know it is to function under the private enterprise system it is essential that Peer Review be effective.

"Peer Review, as the term is now being publicized, sounds to many like a new approach. Physicians know it is not. Documented information from official sources dating back 60 years or more confirm that physicians have embraced self-evaluation and self-discipline and have emphasized their responsibility of assuring the public that only medical care of high quality shall be available to them. For many years physicians at regional and local levels have sponsored and supported the organization and effective functioning of Grievance Committees, Issue Committees, Medical and Surgical Audit Committees, Ethical Practices Committees, Utilization Review Committees, and Prepayment Plans and Organizations Committees", stated Dr. Troxel. "Now Peer Review seems to be designed to subsume these functions", he said, "if not to replace them."

To paraphrase a statement of Mr. Thomas M. Tierney, Director, Bureau of Health Insurance, made at the Clinical Meeting of the American Medical Association in Denver last November, "Peer Review had better be successful, because you wouldn't like the alternatives."

We, of Blue Cross and Blue Shield, offer our support and assistance to Peer Review to serve the best interests of the public and the profession.

Dinner Workshops for Medical Assistants Scheduled

The spring dinner workshops for medical assistants will begin on Wednesday, April 1, 1970 at Augustine's Restaurant, 1200 Centerville Avenue, Belleville, Illinois.

The workshops are intended to aid medical assistants in carrying out their responsibilities more effectively for their physician-employers and to keep them abreast of changes in Blue Shield benefits and ways to file Physician's Service Report forms to prevent delays in payment.

All medical assistants will be invited to attend one of the scheduled workshops and should return promptly the reservation form they receive with their invitations.

For additional information, please write or telephone Mrs. Loretta O'Donnell, Professional Representative, Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 222 North Dearborn Street, Chicago, Illinois 60601. Telephone (312) 661-2964.

(This is not an advertisement.)

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Inpatient Certification and Recertification

The Social Security Administration has notified all Medicare Intermediaries of changes in regulations governing certification and recertification of inpatient care for Medicare beneficiaries.

Payment can be made for covered hospital services but only when the physician certifies that the services are medically necessary. Physician certification and recertification statements should be retained in hospitals' files where they may be verified by the intermediary whenever necessary.

Since January 1st of this year it has been necessary to make the first certification by the 12th day of the patient's hospitalization. The Social Security Administration requires the first recertification as of the 18th day of hospitalization. Medicare regulations further require subsequent recertification to be made at intervals established by the hospital's utilization review committee but not to exceed 30 days.

Medicare regulations make it necessary for certification and recertification records to contain:

1. an explanation of the medical necessity for continued hospitalization.
2. the estimated time the patient will have to remain in the hospital.
3. the plan for post-hospital care.

Certification and recertification must be signed by the attending physician or a member of the medical staff familiar with the case.

There is no requirement that certifications and recertifications be made on specific forms so long as the hospital record contains the above information and is available to the intermediary when requested.

Recertifications may be part of the utilization review plan but must include the information listed above which should be included in the minutes of the review committee.

If recertification is necessary at a time when the whole utilization review committee cannot meet, a subcommittee may be appointed to fulfill the Medicare requirement.

In the absence of documented physician certification and recertification for Medicare patients within the designated time payments to hospitals will not be made.

Attending Physicians in a Teaching Institution

We are frequently asked the question, "What is an attending physician in a teaching institution?"

Directives from the Social Security Administration state that to qualify as the "attending physician" for a period of hospital care, the teaching physician must as a minimum:

- a. review the patient's history, the record of examinations and tests in the institution, and make frequent reviews of the patient's progress; and
- b. personally examine the patient; and
- c. confirm or revise the diagnosis and determine the course of treatment to be followed; and
- d. either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by interns, residents, or others and that the care meets a proper quality level; and
- e. be present and ready to perform any service performed by an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; for the physician to be an "attending physician" his presence as an attending physician must be necessary (no superfluous as where, for example, the resident performing the procedure is fully qualified to do so) from the medical standpoint; and
- f. be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care, at least throughout the period of hospitalization.

The fulfillment of these responsibilities must be demonstrated, in part, by "notes and orders" in the patient's records that are either written by or countersigned by the physician.

A physician in a teaching setting who fulfills the requirements as an attending physician but does so for only a segment of a patient's hospital stay is still eligible for Part B reimbursement if that portion of the stay is "a distinct segment of the patient's cause of treatment"; i.e., a pre-operative or post-operative period; also, the segment must be of significance in the continuity of the patient's care. If the teaching physician is not the "attending physician" for the duration of a segment, he can be reimbursed by Part B Medicare only for those identifiable services which he personally renders.



Edward W. Cannady, M.D.

The President's Page

Let's Support Our Future Physicians

The Illinois State Medical Society and the Texas Medical Association are heading a pilot program to promote Student American Medical Association (SAMA) Sustaining Membership among practicing physicians. ISMS participation in this program was approved by your Board of Trustees and several announcements have already been sent to our membership.

To date, only 29 Illinois physicians have applied for Sustaining Membership in SAMA. I again urge the support of all ISMS in this important program.

Sustaining Membership in SAMA can be a bridge to the next generation of physicians. Your participation can eliminate the general lack of communication and resultant misunderstanding that has occurred between practicing physicians and medical students.

In an effort to effect a closer liaison with SAMA, ISMS has arranged for student representation on most ISMS councils and committees. The student response has been excellent and those appointed to our committees have participated enthusiastically and made intelligent contributions to our meetings.

As a Sustaining Member in SAMA, you will be kept up-to-date on SAMA activities through their monthly publication—SAMA, THE NEW PHYSICIAN. You also have the opportunity to apply your \$15 dues to a specific area of interest including:

- Curriculum Research—this project is attempting to remove the "deadwood" from the medical school curriculum and streamline it to meet the needs of today.

- Career Recruitment—promotes career conferences in an effort to attract potential medical students.
- Internship Evaluation—present interns submit reports of their programs thus giving future interns the benefit of their experience.
- International Exchange—students from foreign countries spend several months in the United States while American students study abroad.
- SAMA Emergency Loan—short term loans (up to \$300) are available at no interest charges to SAMA members.
- General Development—provides funds for programs not previously budgeted for.

In the February issue of *Illinois Medical Journal*, the results of our 1969 Survey of medical students on major issues was published. This survey was the same as the one previously sent ISMS members.

Based on almost 1,000 responses, Illinois medical students share the opinions of ISMS members in 24 out of 27 issues. On the issues of employment of physician's assistants and voluntary service in community health centers, the students felt even greater cooperation was necessary.

Thus, the so-called "generation-gap" is not as wide as previously thought; and I hope whatever differences do exist can be resolved through such programs as SAMA's Sustaining Membership for physicians. You can join by completing the convenient form with this article and returning it with your check. Do it NOW!

A handwritten signature in dark ink, reading "Edward W. Cannady". The signature is fluid and cursive, with the first name and last name clearly legible.

(Turn page for application form)

On Peer Review—

A "giant step" forward was taken by ISMS when it presented Guidelines for establishing county peer review committees at the 1970 Leadership Conference. Nearly 300 physicians from all parts of Illinois attended the Conference and heard ISMS Board Chairman, Dr. Frank J. Jirka, Jr., "tell it like it is."

"This puts you county society people on the starting line," he said. "I plead with each and every representative here today—from the 6,700 member Chicago Medical Society to the 3-member Washington county medical society—to help establish an effective peer review mechanism patterned after the one presented here. One with teeth in it. One that's not afraid to tell the doctor he's wrong when he is. One that

has guts enough to criticize an insurance company when such criticism is deserved. We ask you to do this before our House of Delegates meets in May.

*"Statewide uniformity is a **must** if peer review is going to work for the good of medicine, as well as the public," Dr. Jirka emphasized. He stressed the need to "appoint competent, objective men" to county peer review committees and keep it out of medical politics.*

"If we fumble our peer review opportunity, there will be plenty of politics later—and it will come from Washington. Big Brother is watching us. We've got to watch ourselves . . . and him."

The ISMS Guidelines for County Peer Review Societies are on page 265.

How Could This Happen?

Some interesting figures released by the U. S. Department of Commerce covering the finances of 9,500 governmental units in 38 metropolitan areas for fiscal 1968: General revenue per capita of \$397 **exceeded** expenditures of \$395 by \$2, yet debt **increased** seven per cent to \$551 per capita.

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- ☐ Internship Evaluation
- ☐ SAMA Emergency Loan
- ☐ International Exchange

The patient who has had a myocardial infarction is usually advised by his physician to avoid emotional excitement. All too often his family, acutely concerned, transmits its anxiety to him, urging him to "rest, rest."

How anxiety may interfere

In a study of 336 males who had suffered at least one myocardial infarction, Sigler¹ reports that manual workers showed the lowest percentage of patients returning to work, compared to clerical workers, business and professional men. The author notes that in many cases the mere apprehension that "return to work would shorten life prevents the patient from resuming activities." It is also well known that emotional disturbance is probably the most common cause of cardiac disability in postinfarction cases.¹

The anxiety factor in both *coronary* and *precoronary* patients has recently been discussed by Thomas,² who suggests: "Intensive investigation of the sources and kinds of anxiety, and how destructive forms of anxiety can be identified and relieved may be the next important step in the prevention of coronary heart disease."

Relief of anxiety with Librium® (chlordiazepoxide HCl) often proves a valuable adjunct to medical counsel, reassurance and the total management program; may help prevent the postcoronary patient from regressing into a state of invalidism.

As an adjunct in cardiovascular therapy, Librium® (chlordiazepoxide HCl): Quickly relieves anxiety of mild to severe degree in most cases. Helps expedite cooperation in therapeutic regimen. May be used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, antihypertensive agents

and diuretics. By relieving anxiety, helps encourage productive activities. Has a wide margin of safety and, in proper maintenance dosage, seldom impairs mental acuity or ability to function. Often effective in extended therapy, usually without diminution of effect or need for increase in dosage—in protracted use, periodic blood counts and liver function tests are advisable.

References: 1. Sigler, L. H.: *Geriatrics*, 22:(9) 97, 1967. 2. Thomas, C. B.: *Johns Hopkins Med. J.*, 122:69, 1968.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating

drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Illinois Physicians Take Lead In Controlling Health Costs

A state-wide plan to evaluate the cost and quality of medical care—and curb wasteful practices in medicine—was announced at the 1970 ISMS Leadership Conference, February 9.

The plan, expected to be in full operation within four months, will cover every aspect of medical care including physician services, and private and government health programs, according to ISMS Board Chairman Dr. Frank J. Jirka.

Addressing the Leadership Conference at the Sheraton-Blackstone Hotel, Dr. Jirka urged the 300 participating physicians to help implement the program in every Illinois community because "the health and welfare of our patients are at stake."

Objectives of the program, he explained, are to: (1) conserve the patient's health care dollar; (2) assure the appropriate use of health care personnel and facilities; and (3) maintain the high standards of medical practice.

To accomplish this, Illinois physicians will establish Peer Review Committees—comprised of a full range of specialists and general practitioners—on a county, district and state basis to review complaints on fees, services and private and government insurance programs.

"Physicians will appear before the committee to answer complaints from government agencies, insurance companies or hospitals," Dr. Jirka said. "In turn, doctors may question these institutions on any rule

or regulation that, in their opinion, pads costs and services."

He said most of the state government health programs and major insurance carriers have agreed to abide by the decisions of these Peer Review Committees to help improve the quality and economy of health care.

Dr. Jirka warned that the success of this program will be determined by the strength of the committee. "They must have the courage to tell the doctor when he's wrong . . . and criticize an insurance company or government health program when such criticism is warranted."

"Peer Review, as 'a two-way street,' can bring far-reaching improvements in the provision of health care," Dr. Jirka said. "Now is our chance to act, instead of merely reacting."

Dr. Jirka also urged doctors to take a careful look at themselves through the review mechanism.

While "bad apples" in the medical profession have received notoriety, "even the finest apples can have a spot or two," he said. "Honorable physicians can overcharge, overuse facilities, over-prescribe—because of fixed ideas or excessive caution, confusion over government regulations, or because the patient wants luxury without anticipating the cost."

On page 265 of this issue will be found suggested Peer Review Guidelines.

ISMS ANNUAL CONVENTION

May 17-20

SHERMAN HOUSE

Chicago

ON THE COVER

Appearing on the cover this month is a "white on white" photographic essay executed by Mike Ahearn, Chicago artist and photographer. The theme is a depiction of the tools of medical research and ties in with the feature article beginning on page 229, "Clinical Cancer Chemotherapy" with a view to a particular application.

Abstracts Of Board Actions

Board of Trustees Meeting

January 17-18, 1970

Ambassador East Hotel, Chicago

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

Health Care Coordination

Results of the December 7 Conference of statewide health care organizations to discuss problems in health care delivery were reported by Dr. E. W. Cannady. The Conference was called by the Illinois Regional Medical Programs at the request of Albert Snoke, M.D., newly appointed coordinator of health services for Illinois. Governor Ogilvie gave emphasis to the conference by making a brief appearance. The Board also received a report on a follow-up meeting between ISMS representatives and Dr. Snoke on January 7.

Medical School Enrollment

The enrollment in Illinois medical schools is scheduled for dramatic increases according to a report given by Dr. Philip Thomsen. Both the publicly operated and private schools are now moving to implement the Board of Higher Education plan (Campbell Report). The private school enrollment is expected to rise from 1,819 to 2,901 by 1972 with 799 of the increase being Illinois residents. These figures include the reactivated Rush Medical School which will open in 1971. The University of Illinois will increase from the present 825 in all four classes to 1,816 by 1976 or earlier. The plans include the activation of the planned clinical centers at Rockford, Peoria and Urbana with the Chicago Circle campus used for pre-clinical training. The Southern Illinois University School will open in 1971 with 50 students.

The Health Education Commission, reviewing arm of the Board of Higher Education, has recommended the necessary funding in the fiscal '71 budgets of the state operated schools and \$17.1 million state subsidy to the private schools. Inclusion of these amounts in the Governor's budget which goes before the Illinois General Assembly in April, is essential to the plan.

Physician Licensing

The Board received expressions of discontent from several sources regarding the delays and difficulties in securing an Illinois license by physicians transferring from other jurisdictions. A committee of Board members was appointed to meet with the Medical Examining Committee of the Department of Registration and Education to discuss needed changes in the laws or licensing procedures. The Committee was also charged with the responsibility for developing suggested changes in the Medical Practice Act to accommodate a proposed shortened medical school curriculum.

(Continued on page 293)

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**His heart tells him he's an invalid.
You know he's not.**

Clinical Cancer Chemotherapy Aimed At Cellular Control Mechanisms

BY FRANCES E. KNOCK, PH.D., M.D., RAYMOND M. GALT, M.D., Y. T. OESTER, M.D., PH.D., OLIVER V. RENAUD, M.D., ROBERT SYLVESTER, B.S., MYRON RUBNITZ, M.D., ALICE DAKIN, M.D., ROSEMARIE HAEFLIGER, R.N., BETTY THOMSON, R.N. AND THOMAS BAFFES, M.D./CHICAGO, HINES

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Cancer surgery and radiation therapy are often local treatments for disseminated disease. Whether or not distant metastases are recognized, they frequently doom attempts at curative surgery. To supplement local treatment of cancer by surgery and radiation, some form of generalized treatment may be needed. Drug therapy is the most commonly used form of generalized treatment for disseminated cancer.

For drug treatment to supplement major cancer surgery, the drugs must attack cancer preferentially. If all rapidly dividing cells are attacked by the anticancer drugs, the patient's wound healing and hematologic status will also suffer, to bar use of many anticancer drugs after major surgery. By contrast, preferential attack by drugs on cancer cells can permit clinical cancer chemotherapy in the immediate postopera-

tive period before cancer cells spread by the surgery become implanted or before residual cancer takes off on a spurt of growth under the stress of surgery.¹⁻⁴

Marked damage to normal wound healing and marrow has characterized much cancer chemotherapy with drugs like nitrogen mustard and 5-fluorouracil. These drugs attack nucleic acids or depress the synthesis of nucleic acids.

To control normal cell division, nature herself apparently aims at a different target: proteins bearing vulnerable groups which may regulate cell divisions and nucleic acids.⁵⁻⁹ Similarly, selected drugs aimed at vulnerable groups on proteins have been found to attack human cancer cells more than normal cells.^{1-4,6-11} Essential protein-sulfhydryl or SH groups are the targets of the clinically useful anticancer

drugs termed sulphydryl or SH inhibitors. In clinical use, selected SH inhibitors have regressed a variety of human carcinomas, sarcomas and lymphomas without apparent injury to wound healing and with minimal injury to hematologic status or even improvement in some patients.

The targets of the SH inhibitors, essential protein-SH groups, are known to play important roles in cell division and metabolism. From cell membranes to chromosomes, protein-SH groups are also believed to play essential roles in cellular control mechanisms.¹⁻¹¹ To earlier data on the importance of protein-SH groups for cell and nuclear membranes, chromosomes, mitotic apparatus, mitochondria, ribosomes and pentose shunt mechanism have been added more recent data on the essential roles of protein-SH groups for natural cell growth factor,¹² immunity against cancer¹³ and estrogen reception.¹⁴ Thus, the growth factor of Sayre is an SH-bearing protein with its actions highly sensitive to the state of its SH groups while the natural cell growth inhibitor of Szent-Gyorgyi is an SH inhibitor.¹⁵ SH-bearing residual protein of chromosomes, which is tightly bound to DNA, has been suggested as a regulator of DNA and the site of essential radiation, steroid and chemotherapy effects.^{1-4,6-11,15-18}

For our present coordinated surgical-chemical therapy of cancer, oxophenarsine was the first potent SH inhibitor available for clinical use. This drug has been used extensively in the past for treatment of syphilis. Since oxophenarsine contains arsenic, to minimize the amount of the drug used for any one course of cancer chemo-

therapy, efforts have been made to extend its effects by use of adjuncts and to develop newer SH inhibitors containing no arsenic.¹⁷⁻²⁰

The first 35 patients treated by combination of oxophenarsine plus adjuncts Synkayvite (menadiol diphosphate), malonate, fluoride and heparin are described in this paper, as well as the first 10 patients treated by the SH inhibitor iodoacetate with the same adjuncts. Iodoacetate contains no arsenic.

Methods

Sensitivity tests on each patient's living cancer cells are used to direct chemotherapy with new and old SH inhibitors and all other types of anticancer drugs. The tests used resemble antibiotic disc sensitivity tests.^{1,2,19,20} Immediately after surgery, each patient's living cancer cells are dissected free of normal tissues and necrotic cancer, then minced in complete tissue culture media containing human serum. No contamination, drying, leaching by saline, glucose, formaldehyde or other noxious media can be tolerated lest the patient's cancer erroneously appear to be sensitive to many anticancer drugs. Results are read by midnight of the day of surgery to guide immediate chemotherapy. Usually within 24 to 48 hours of major cancer surgery the patient is started on the drugs most active against his own cancer.^{2,4,20} Complete details of the surgical dissection, tissue culture methods, chemical studies and clinical protocol have been published.^{2,10,11,19,20}

Patients receive full benefit of aggressive surgery, radiation therapy and endocrine



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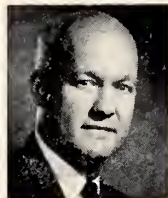
(Photo courtesy of Stuart-Rodgers Studio.)



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therapy along with any needed drug therapy directed by the sensitivity tests on each patient's own cancer. Fortunately, selected SH inhibitors not only are of low enough toxicity to be used with radiation therapy but frequently appear to potentiate radiation therapy.² Such potentiation has been documented for iodoacetate and a variety of other SH inhibitors against bacteria and leukemia cells,²¹ and has been seen by Mitchell and co-workers with the SH inhibitor Synkayvite in the radiation therapy of human cancers.²²

Synkayvite and oxophenarsine are commercially available for clinical use. Sodium fluoride and sodium malonate are sterilized by passage thru a bacterial filter.²⁰ Iodoacetic acid is self sterilizing and an excellent broad spectrum antibacterial

agent. Commercially available iodoacetic acid, however, is not pure enough for intravenous use. It is recrystallized from ligroin to obtain a pure white solid of constant melting point. Individual doses are weighed out, stored in the deep freeze, then neutralized with clinical grade sodium bicarbonate solution just before injection to the patient.

Patients or their guardians give a fully informed, written consent for all therapy.

Results

Table 1 lists the first 35 consecutive cases treated with the SH inhibitor oxophenarsine plus adjuncts Synkayvite, malonate, fluoride and heparin.

Twenty-seven of the 35 patients were determinate for effects of chemotherapy.

Table 1. Response of Human Tumors to SH Inhibitor Oxophenarsine Plus Adjuncts

Primary Tumor	Number of Cases	Indeterminate Cases	Determinate Cases	Progression	Regression by SH Inhibitors Alone		Regression by SH Inhibitors Plus Other Drugs
					Partial	Good	
Colon and Rectum	8	4	4	2	2		
Stomach	2	1	1		1		
Breast	3		3			2	1
Ovary	4	2	2			2	
Melanoma	4		4	1	2	1	
Lung, Oat Cell	2		2		1		1
Bronchogenic	2		2	1	1		
Epidermoid Cancer pharynx	4		4		2	1	1
Thyroid	1		1	1			
Sarcoma	1		1	1			
Choriocarcinoma, testicle	1		1				1
Hodgkin's Disease	1		1			1	
Urinary Bladder, transitional cell	1				1		
Uterine Cervix	1	1					

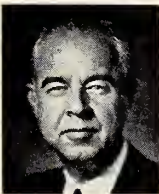
Y. Thomas Oester, M.D., is Associate Chief of Staff for Research and Education at the Veterans' Administration Hospital and Professor, Pharmacology, at Loyola University, Stritch School of Medicine.



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Raymond M. Galt, M.D., is in internal medicine. (Photo by Joseph Merante.)
Thomas G. Baffes, M.D., (not pictured) is attending surgeon at Augustana Hospital, Swedish Covenant, Illinois Central and Lutheran General.



Rosemarie Haeflinger, R.N. (right) is an intravenous therapist. (Photo courtesy of Stuart-Rodgers Studio.)
Betty Thomson, R.N., (left) is an intravenous therapist.



In six of the 27, the disease progressed despite chemotherapy. The majority of patients (21 of 27) whose tumors could be measured objectively received objective benefit (either a \pm or $+$ effect, partial or good regression) from chemotherapy with the SH inhibitors alone or in combination with other drugs whose selection was guided by sensitivity tests on each patient's own cancer. No long term results can be assessed for the SH inhibitor oxophenarsine since its arsenic content prevents prolonged administration.

Clinical toxicity has been described previously:^{19,20} especially some pain at the site of intravenous injection, usually controlled by cold packs; and nausea, usually controlled by antiemetics. During rapid regressions, the patients may also note anorexia and lassitude, with night sweats and some febrile response as well. In one patient, who received the most prolonged treatment with oxophenarsine (described in Case 1 below), incipient optic neuritis and diplopia were produced which cleared rapidly when chemotherapy was withdrawn. Side effects with the iodoacetate at the same dose used with oxophenarsine (6 doses per week of 60 mg each^{10,11}) have, in general, resembled those with oxophenarsine but tend to be considerably milder than those with oxophenarsine.

Of the first ten patients treated with iodoacetate plus adjuncts Synkayvite, malonate, fluoride and heparin, only three were determinate for effects of chemotherapy. Since radiation therapy has frequently been combined with iodoacetate because of the known potentiation of radiation therapy by iodoacetate, a larger number of indeterminate cases can be expected for iodoacetate. Our impressions on clinical use of iodoacetate confirm the potentiation by iodoacetate of radiation effects reported by other workers.²¹ Regression appears to be more complete or more rapid with simultaneous administration of iodoacetate to patients undergoing radiation therapy. Fortunately, simultaneous potentiation of radiation effects against normal tissues, which would also be expected, has presented no clinical problems to date.

Of the three patients who could be evaluated for effects of iodoacetate alone, two of three obtained objective regressions. Iodoacetate failed to prolong for more than

several weeks the excellent regression produced by oxophenarsine plus adjuncts in a patient with widely disseminated melanoma. Chemotherapy with iodoacetate was therefore listed as a failure for this patient. In the other two patients, one with disseminated carcinoma of the colon and one with massive carcinomatosis of the ovary, objective regressions were produced by iodoacetate plus adjuncts Synkayvite, fluoride, malonate and heparin. The patient with ovarian cancer is presented in detail below in Case 1.

In a larger series,²³ Black, Kleiner and Bolker noted objective regressions in the majority of patients treated with iodoacetate plus adjuncts fluoride, malonate and in some cases azide. For our present coordinated surgical-chemical program of cancer therapy, azide has been found to be too toxic and too unpredictable in its toxicity for our consideration. Table 2 summarizes results of Black, Kleiner and Bolker with iodoacetate plus adjuncts.

Clinical Effects of Iodoacetate Plus Adjuncts

TYPE OF NEOPLASM	RESULTS
Acute myeloblastic leukemia	5 of 10 improved
Acute lymphatic leukemia	4 of 4 improved
Acute moroblastic leukemia	No effect in 1 case
Gastric carcinoma	2 of 2 improved
Lymphosarcoma	1 of 1 improved
Carcinoma of colon	3 improved initially
Carcinoma of lung	4 of 4 improved
Carcinoma of testis	2 of 2 improved
Hodgkin's disease	3 of 3 improved

Table 2. Clinical Effects of Iodoacetate Plus Adjuncts (Black, et al.²³)

Report of Cases

Case 1 A 39 year old white female was admitted with massively disseminated ovarian cancer. She was reported to have obtained originally objective regression but extreme marrow depression from treatment with cytoxan and subsequently melphalan, forcing discontinuation of the alkylating agents. During withdrawal of the drugs, her pelvic cancer had enlarged to above the umbilicus, with another hard mass in the right upper quadrant. On admission to this hospital, her first regression of over 50 percent, to 9 cm below the umbilicus, was produced by a course of 26 injections of oxophenarsine plus adjuncts. The regression was not maintained during outpatient chemotherapy with myleran. She was readmitted, with multiple bowel obstructions,

the highest in the upper jejunal area. Chemotherapy with another 24 injections of oxophenarsine plus adjuncts gradually relieved her bowel obstructions and produced a second regression of her pelvic cancer. Unfortunately, incipient optic neuritis and diplopia were also produced, forcing discontinuation of the sulfhydryl inhibitors. The diplopia and optic neuritis cleared rapidly following discontinuation of the drugs.

Attempts were then made to hold her second regression by chemotherapy with cytoxan plus Synkayvite. Again maintenance chemotherapy as an outpatient failed to hold her regression produced by the SH inhibitors. She was readmitted with her pelvic mass rising out of the pelvis to 2 cm below the umbilicus. Permission from the Food and Drug Administration to use iodoacetate plus adjuncts clinically was obtained after she received four injections of oxophenarsine plus adjuncts. Immediately, the patient was switched to chemotherapy with iodoacetate plus adjuncts. Her pelvic mass shrank to 8 cm below the umbilicus after 20 injections. She was sent home on iodoacetate plus adjuncts as an outpatient, but was admitted shortly thereafter as an emergency because of a low bowel obstruction in the rectosigmoid area. This obstruction persisted despite intubation, suction and further chemotherapy with iodoacetate plus adjuncts.

The patient was then explored and found to have regressed most of her massive cancer. An orange-sized mass remained above the bladder, into which had been dragged descending colon and transverse colon, along with multiple loops of small bowel, which could not be freed because of their fragility and danger of hemorrhage. An ascending colon colostomy was done as well as a gastrojejunostomy to by-pass a mass of adhesions and cancer in the right upper quadrant, the probable site of her earlier high obstruction.

Postoperatively, on chemotherapy with iodoacetate plus adjuncts, she obtained another regression of her right upper quadrant mass. Later she developed also a small bowel obstruction, not unexpected from the mass of adhesions produced by regression of her multiple deposits of cancer. Unfortunately, she developed again an incipient optic neuritis, forcing discontinuation of her iodoacetate chemotherapy and leav-

ing no safe chemotherapy to cover reexploration for relief of her bowel obstruction. This was treated conservatively without success and she expired.

Comment This patient's course illustrates some of the problems encountered during successful chemotherapy for cancer in patients with massively disseminated disease.²⁰ Unfortunately, regression of a napkin ring type of lesion encircling any hollow viscus, can convert a partial obstruction to total obstruction as the whole of the napkin ring grows smaller during shrinkage of the ring. This effect was seen in the patient above and constantly threatens cancer patients whose tumors about any hollow viscus (bowel, ureter, bile ducts, etc.) are regressed by chemotherapy.

Case 2 A 53 year old engineer was admitted with a diagnosis of extensive epidermoid carcinoma of the larynx invading also the esophagus. Symptoms of hoarseness, voice change and some difficulty swallowing had been present for about one year. Laryngoscopy and esophagoscopy revealed the esophagus to be markedly distorted by direct invasion and about half of the circumference of the larynx to be involved. On exploration of the neck, a large cervical cancer mass was found to invade the carotid artery for about an inch at its midportion. The local neck cancer was cut across where it extended into carotid artery and the excised tissue used for sensitivity testing. Part of the excised cancer was stored at -85°C for eventual preparation of an autogenous vaccine. Laryngectomy and esophagectomy were precluded by the extent of the local lesion and its longitudinal spread.

In the drug sensitivity tests, the patient's cancer was most sensitive to oxophenarsine plus adjuncts, with less sensitivity to hydroxyurea, cytoxan and methotrexate. He received a course of chemotherapy with the SH inhibitors, along with autogenous vaccine made from cancer invading his carotid artery by the method of Finney, Byers and Wilson.²⁴ Cobalt therapy (6500 r) was combined also with chemotherapy and vaccine therapy. The patient was maintained on oral hydroxyurea after his return home to another state.

Two years later he was readmitted with a tracheoesophageal fistula. In the interim, he had regained his strength, worked six days a week full time and weighed more

than at any time previously. At laryngoscopy, no cancer could be seen. A gastrostomy was performed, and his neck reexplored, but no cancer was found, only scar tissue. He was treated with a repeat course of oxophenarsine plus adjuncts. He was about ready for discharge on oral cytoxan when he developed a pneumonitis during an epidemic of Hong Kong flu. Myocardial insufficiency developed rapidly and the patient died despite digitalization and antibiotics. No autopsy was permitted.

Comment The patient is indeterminate for effects of chemotherapy because this was given with vaccine therapy, as well as local treatment by palliative surgery and radiation therapy. Probably all four forms of therapy helped the patient. The significance of the case stems from the fact that a combination of useful treatments, which can be combined without injury to the patient, offers hope of helping patients whose local and distant disease would otherwise provide a dismal prognosis. During the two years of regression following chemotherapy, vaccine therapy, palliative surgery and radiation therapy, the patient made outstanding scientific contributions to the nation's space program.

Case 3 A 40 year old white male was first seen with a large mass in his right neck. Pelvic lymphangiograms demonstrated probable dissemination of his disease to the pelvis. Local excision of the neck mass showed malignant lymphoma, lymphoblastic type, composed of very young, immature cells.²⁰ His tumor was most sensitive to oxophenarsine and adjuncts plus cytoxan. Postoperatively, the patient received a course of chemotherapy with the SH inhibitors along with palliative radiation therapy of 3500 roentgens to anterior and posterior portions of the neck. He tolerated the combination therapy well. Finally, the patient received an autogenous vaccine made from his neck tumor excised surgically and held at -85°C since the palliative surgery. Subsequently, no other therapy was given after the vaccine therapy. The patient was followed closely as an outpatient.

Five years later, a fibrolipoma was excised from his left forearm and a ganglion of traumatic origin excised from his right wrist. His sedimentation rate is 3, his BUN 15 and his IVP and other laboratory studies

are normal. Clinically, the patient is free of disease.

Comment The patient is indeterminate for effects of chemotherapy with the SH inhibitors because chemotherapy was given along with radiation therapy and followed with vaccine therapy. The patient demonstrates, however, the type of coordinated surgical-chemical therapy for cancer, which is sought for all patients in our work, but which frequently cannot be given because of the moribund state of the referred patients.

Discussion

The clinical program continues to be focused on the welfare of each individual cancer patient. The work does not constitute a prospective randomized study on selected individuals for research purposes.^{2,10,19,20} Patients receive chemotherapy with the SH inhibitors or other drugs in accord with sensitivity tests on their own tumors.

For a wide variety of drugs, active and inactive, the sensitivity tests used have agreed well with statistically significant assays of drug effects against animal cancers.¹⁹ The sensitivity tests have correlated well with clinical results in two series of patients, those of Watne and Di Paolo²⁵ and our own.

Specifically, the informed, written consent given by the patient or his guardian states that the patient is to receive drugs in accord with sensitivity tests on his own tumor, that he is not part of any randomized study and will not be used as a control. The ethical implications of the work have been discussed in detail.^{2,19,20,26-29}

In the patients described above, oxophenarsine was used first because it was the first potent SH inhibitor available for clinical use. Subsequently permission has been granted by the FDA for use of iodoacetate, often more active than oxophenarsine and more useful because it contains no arsenic, permitting use for prolonged periods. Activity of these two SH inhibitors is, however, often exceeded by that of newer SH inhibitors, now being made ready for clinical use (Figure 1).^{17,30-32} Many SH inhibitors must be made available for patients, from which the best can be chosen for each patient, just as multiple antibiotics are needed to treat *Staph aureus* infections,

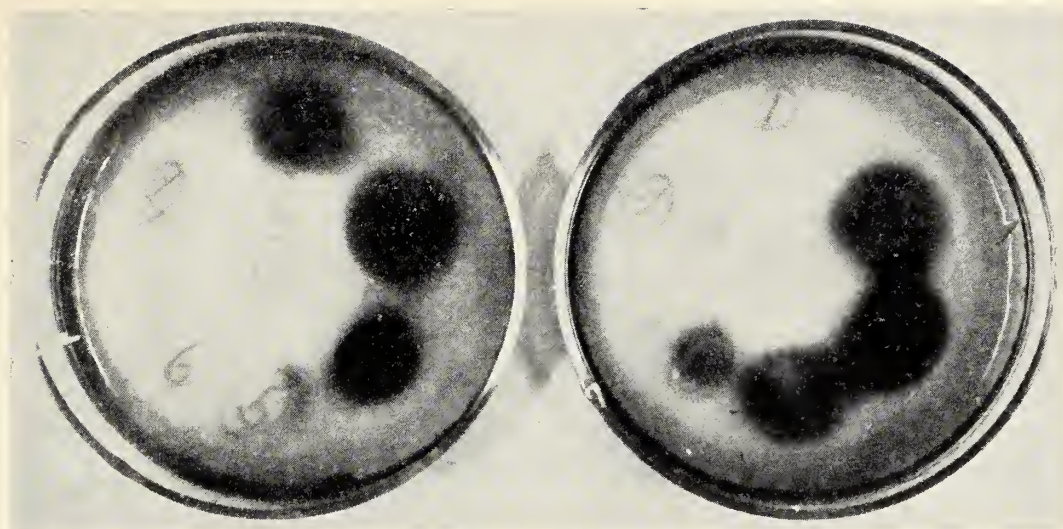


Fig. 1. Agar plate assays on histologically similar adenocarcinomas of the breast from two different patients. In these sensitivity tests, the larger the dark area, the more active is the drug at that spot in depressing dehydrogenase activity of the cancer cells. In both plates, oxophenarsine plus adjuncts is at 12 o'clock and iodoacetate plus adjuncts at 6 o'clock. Newer SH inhibitors, being made ready for clinical use, are present at other positions. In the plate at the left, oxophenarsine plus adjuncts displays more activity against the cancer cells than does iodoacetate plus adjuncts, while the reverse is true for the breast cancer cells

on the right. In other plates, however, oxophenarsine plus adjuncts for both patients demonstrated far more activity than alkylating agents, 5-FU, methotrexate and vincristine. Both patients were treated with oxophenarsine plus adjuncts. The one on the right obtained an excellent clinical regression; the one on the left was indeterminate for effects of chemotherapy. The tests above demonstrate the marked chemical heterogeneity of histologically similar human cancers. Such sensitivity tests guide synthesis of improved SH inhibitors, more active than oxophenarsine or iodoacetate against cancer cells from many patients.

from which the best is chosen by sensitivity testing for the given infection in the given patient.

Quantitative relations markedly influence results with any given SH inhibitor. Greater amounts of cancer lead to greater pools of SH-bearing proteins and less complete attack by 60 mg for example, of a given SH inhibitor. As a result, less toxic SH inhibitors, which can be given in large amounts to patients, are constantly being sought.

Oxygen: SH Inhibitor

Oxygen itself is an SH inhibitor, among other effects. Hyperbaric oxygen has been shown to react with protein-SH groups of human cancers.^{2,19} Potentiation of chemotherapy with the SH inhibitors would therefore be expected from pretreatment of the patient and his cancer with the SH inhibitor hyperbaric oxygen. By contrast, no special potentiation by hyperbaric oxygen would be expected, nor has any been documented, for cancer chemotherapy with drugs like methotrexate and 5-fluorouracil.

With animal cancers, hyperbaric oxygen has been found to potentiate chemotherapy with SH inhibitors like oxophenarsine and iodoacetate, as expected. Clinically, results of combining hyperbaric oxygen with the SH inhibitors appear promising.¹⁸

Like hyperbaric oxygen, L-tryptophane may also be a useful adjunct for chemotherapy with the SH inhibitors. Gold has suggested clinical use of tryptophane to decrease cachexia through its known ability to decrease gluconeogenesis by blocking phosphoenolpyruvate carboxykinase.³³ In agar plate assays and animal studies, L-tryptophane potentiates significantly the activity of potent SH inhibitors like iodoacetate and N-iodoacetylphenylalanine against a variety of animal and human cancers. The use of tryptophane to potentiate activity of SH inhibitors may break more effectively the energy cycle of glycolysis-gluconeogenesis important to cancer cells than can either the SH inhibitors or tryptophane alone.

Whatever may be the ultimate chemical mechanism, tryptophane like hyperbaric oxygen appears to be a useful adjunct for

chemotherapy with potent SH inhibitors. Fortunately, in animal studies to date, neither tryptophane nor hyperbaric oxygen has increased significantly the toxicity of clinically useful SH inhibitors.

Cellular Control Mechanisms

Cancer probably devolves to derangements in cellular control mechanisms for mitosis. Little is known about such regulatory mechanisms except that huge numbers of chemical reactions must occur simultaneously or in interrelated rapid sequence for mitosis to occur. Either huge numbers of separate control mechanisms and separate chemical receptors for regulators are involved, or a single common chemical denominator may be crucial in triggering on and off the host of reactions. Because of its simplicity, the latter hypothesis may be the more probable.^{5,11}

Selected SH inhibitors can attack cancer preferentially, suggesting that protein-SH groups may play essential roles in the differences between cancer and normal and in cellular control mechanisms from cell membranes to chromosomes. The data have been reviewed by Knock, Galt and Oester.^{1-4,6-11,18}

SH-bearing proteins are known to be essential to the integrity of cell membranes. Correspondingly, selected SH inhibitors can cause preferential blebbing of cancer cells, associated with loss of DNA, protein dehydrogenase activity and lactic acid production. Large and consistent differences have been found between cancer and normal in electron spin resonance signal. Here, SH-bearing succinic dehydrogenase of mitochondria is known to play a large role. Physical-chemical differences have been reported between cancer and normal in the pentose shunt mechanism, where SH-bearing dehydrogenases play essential roles. In immunity against cancer, SH groups are believed to play important roles. Estrogen reception is now known to depend upon integrity of protein-SH groups in the receptors, whereas the natural cell growth regulator Retine of Szent-Gyorgyi is an SH inhibitor, the natural cell growth factor of Sayre is an SH-bearing protein remarkably dependent on its protein-SH groups for biological functioning. SH-bearing residual protein of chromosomes is essential to their structural integrity and has been suggested as a regulator of DNA and site of essential

chemotherapy, steroid and radiation effects.

Data from many sources suggest that appropriate state of essential protein-SH groups from cell membranes to chromosomes may trigger the host of chemical reactions involved in mitosis and that essential protein-SH groups from cell membranes to chromosomes may be the common chemical denominator in cellular control processes.

Even if protein-SH groups in multiple crucial areas of the cell do not participate directly in cellular control mechanisms, their importance for conformation and allosteric effects has been well documented. The greater disorder and entropy of cancer cells relative to normal cells would be expected to increase the availability of crucial protein-SH groups in cancer cells for reaction with selected SH inhibitors. Thereby, preferential attack on human cancer becomes possible, in accord with sensitivity tests and clinical data.

Summary

From cell membranes to chromosomes, sulfhydryl or SH groups on protein appear essential to the differences between cancer and normal cells. Selected SH inhibitors aimed at essential protein-SH groups have regressed a variety of human cancers without injury to wound healing and with minimal injury to hematologic status, or even improvement in some patients.

Two potent SH inhibitors, oxophenarsine and iodoacetate, plus adjuncts Synkavite, malonate, fluoride and heparin, are being used clinically with promising results. The majority of patients whose cancers could be measured objectively have obtained a regression from the SH inhibitors alone or in combination with other anticancer drugs. Cancer chemotherapy with SH inhibitors and other drugs is directed by sensitivity tests run immediately after surgery on each patient's living cancer cells. From animal studies and sensitivity tests on human cancers, hyperbaric oxygen and L-tryptophane appear to potentiate cancer chemotherapy by active SH inhibitors. Initial clinical studies with hyperbaric oxygen and SH inhibitors appear encouraging.

To earlier data on the importance of protein-SH groups for cell and nuclear membranes, chromosomes, mitotic appara-

tus, mitochondria, ribosomes, and pentose shunt mechanism have been added more recent data on the essential roles of protein-SH groups for natural cell growth factor, estrogen reception and immunity against cancer. Proper state of protein-SH groups from cell membranes to chromosomes may play an essential role in cellular control mechanisms and may be responsible for triggering the host of chemical reactions involved in mitosis.

Patients for this study were referred by Drs. Paul Holinger, Joyce Schild, Dino Maurisi, Hiram Langston, Walter Barker, Bernard Leininger, George Milles, Thomas Longabaugh, George Brebis, Joseph Kiefer, John Jacobs, Clement Mobaker, Robert Kleompken, Frank Carter, James Cole, Lydia Kolomicjew, James Burden, Naime Nasralla, James O'Neill, Mary Johnson, David Lockman, and Geza de Takats. This study was aided by grants from the Augustana Hospital Cancer Fund and the Knock Research Foundation. ◀

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THE VIEW BOX

BY LEON LOVE, M.D.

*Director, Department of Radiology, Loyola University Hospital
and Chairman, Department of Radiology, Loyola University
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60-year-old man entered the hospital complaining of a mass which had been increasing in size for the past six years. On the posterior medial aspect of his mid-thigh he recalled ten years ago he had suffered a gunshot wound at approximately the same location. What's your diagnosis?

1. Paraosteal Sarcoma
2. Aneurysmal bone cyst
3. Traumatic A-V fistula with calcification
4. Cortical metastasis

(Answer on page 302)

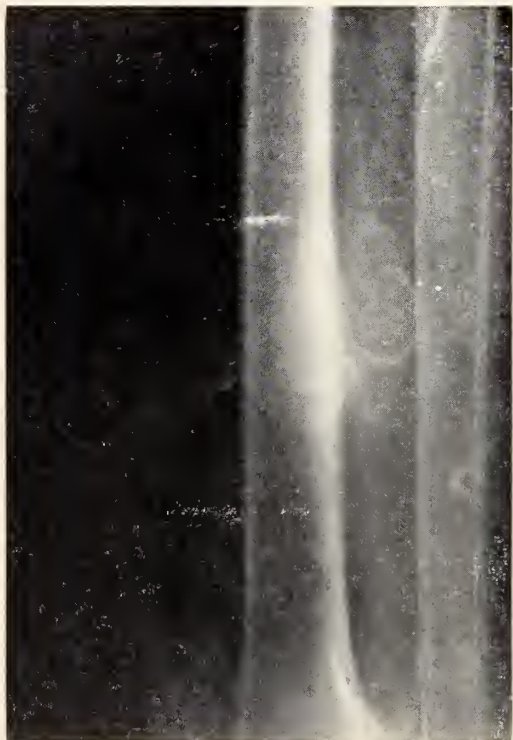


Fig. 1

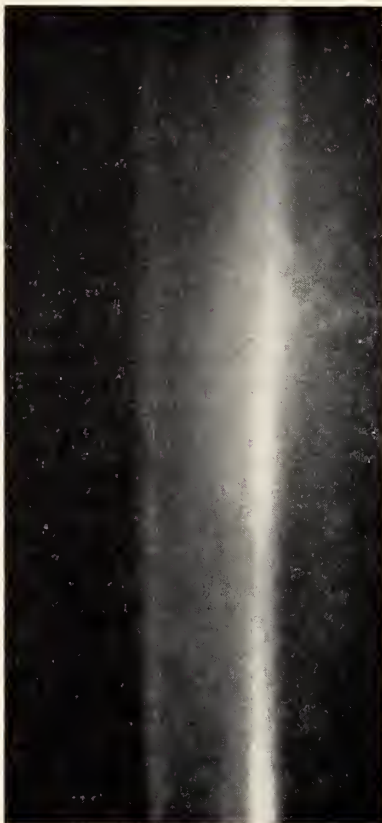


Fig. 2



Fig. 3

Our Responsibilities

BY PAUL C. BUCY, M.D./CHICAGO

Leroy Sloan was a fine gentleman, an outstanding physician, a good teacher and a public spirited citizen. It is most fitting that we should honor his memory. But it is not enough that we should honor him in words. Deeds also are called for, and what we as a profession have done and are doing is not enough. We have not adequately shouldered our responsibility. As Dr. John H. Knowles of the Massachusetts General Hospital has said recently in regard to this matter, "We have met the enemy and they are us!"

In recent years we, the medical profession, have been concerned about what has been termed "Our public image." We are hurt and we often do not understand when we fail to receive the public respect to which we think our accomplishments entitle us. We look back nostalgically to a time when the "family doctor" was one of the most revered and respected members of our community. We fail to understand why a distinguished gentleman in a long tailed coat, with a nose-gay in his button-hole and a gold headed cane was more respected than we are. He had little to offer except dignity and sympathy, while we have subdued or conquered diabetes, pernicious anemia, tuberculosis, pneumonia, infantile paralysis and many other human afflictions and have prolonged human life in vigor and in comfort by many, many years. To this the answer of the public is "Yes, but what have you done for me today and what will you do tomorrow."

We as a profession, and hopefully as well educated, public spirited citizens, have allowed our vision to be too narrowly channeled.

What has been done in the diagnosis and treatment of disease has been outstanding and has, I insist, been fully recognized and appreciated by the people. But it is not enough. We must do more than each

going his own little way, giving his patients the best care of which he is capable. By training and experience we are or should be the best informed and most understanding body of men and women, regarding human welfare, in this country. But instead of taking leadership and directing the efforts of this country in the health and well being of its citizens we have allowed such activities to slip largely into other hands. By our inactivity these matters have of necessity become the responsibility of the politician, or the social and welfare worker.

We are not pleased with the results but we do little about it. We do not like socialized medicine but we have fought every effort that has been made to avoid socialized medicine. Surely most can recall our opposition to hospital insurance, to medical insurance, and to medicare and medicaid. Yet, without these programs governmental operation of our hospitals and of medical care would today be a necessity, if not already an accomplished fact. It is no excuse for any of us to insist, "Oh, but I did not oppose these programs; they were opposed by organized medicine." That

*This paper was presented as The LeRoy Sloan Memorial Lecture to the medical staff of the Illinois Central Hospital, Chicago, Feb. 18, 1969.

is no good. This is not a responsibility which we can deny for we *are* organized medicine, or if anyone of us is not, he should be. If our medical societies or our medical leaders do not take prompt, effective action, it is our responsibility to indicate to them where they are going wrong and either see that they correct their errors or replace them. Too many of us are willing to sit back and criticize the American Medical Association, our local and state medical societies, and their elected leaders, without being willing to participate in their activities and their direction. It is long past the time when every one of us must participate. It is not enough to sit back and shout "Socialized Medicine." We now have socialized medicine, and we have had it for a long time. What do you think our tuberculosis sanitariums, our state mental hospitals, our veterans administration hospitals are if they are not socialized medicine? It is not a question of governmental participation in health matters, it is only a question of how. I am as much opposed to the complete control of medicine by governmental agencies as many others. I have seen governmental control of the medical profession and the hospitals all over the world. It has deficiencies.

I have seen it in England, which has hardly built a new hospital or renovated an old one since their system of socialized medicine was introduced: in Finland, where the professor of neurological surgery must decide in a telephone conversation whether a given patient is one he is likely to be able to help, or one he must turn away to die without specialized care because of the lack of adequate hospital facilities: in Sweden, where a professor of surgery on government salary restricts his practice almost entirely to a few non-Swedish patients a year because he doesn't want to work very

hard and because the foreign patients can pay him a surgical fee which Swedish patients cannot: or again in England where the cream of every new crop of physicians and scientists is leaving the country for freedom and more attractive places elsewhere and where this loss is being repaired by the hundreds by less well trained doctors from India, Pakistan and Africa.

But all is not bad in these countries with socialized medicine. In all of Europe people who could not obtain or could not afford adequate medical care now have it available to a far greater degree than ever before. There are also many parts of the world where the economy is so poor that anything remotely approaching adequate medical care would not be possible except under governmental direction. Mexico is an outstanding example of this. What that country has accomplished through federal agencies in providing clinics and hospitals even in remote parts of the country is outstanding. This is socialized medicine and it is just as desirable as the successful efforts of the government to provide education for the children in practically every Mexican village.

Why The Image Is Tarnished

If you would understand why the "public image" of the medical profession has become tarnished, the explanation resides in one word—"No." The attitude of the medical profession must change. We must adopt a positive not a negative approach to so many problems of public health. How ridiculous was our opposition to hospital insurance when we knew better than anyone else the financially catastrophic effects of illness upon the average family. Why should not the working man insure himself against the expense of illness just as he already insured himself against destruction of his home or his car? Yet for years the medical profession opposed hospital insurance without presenting any positive solution to a problem which was apparent to every thoughtful physician. Every one of us is aware of the problems of hospital and medical costs for the working man who is retired and who is living on a small pension or upon the even less adequate income of social security. Yet what positive steps did we take to meet this problem? Only when we saw the impending certainty of medicare for those over 65 did we propose



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an ill-considered and inadequate substitute. As a result we now find this country burdened with an unsatisfactory program which few like but which is meeting the problem. This is a program designed by sociologists and adopted by politicians, but only after we did nothing about it. If we do not like it, we have only ourselves to blame for not having acted and acted first. We should never wait for these non-medical people to take action in an area which is or should be most evident to us.

Are these the only areas in which action needs to be taken? By no means! There is still plenty to be done. What are some of the things known to all of us which we are even now neglecting? One of the most glaring is in our backyard. The Cook County Hospital. What are you doing about "County"? What is organized medicine doing about "County"? With the exception of a few outstanding devoted people, such as Bob Freeark, very, very little. Is this because you do not know that Cook County Hospital for years has been on probation as a suitable institution for the training of interns and residents? Is this because you do not know that Cook County Hospital is sorely lacking in adequate nursing care? Is this because you do not know that Cook County Hospital has been badly in need of renovation and modernization for many years? Is this because you do not know that many of the problems of County result from the fact that it is a political empire controlled by a County Board that knows little or nothing about hospital operation and medical care, and which is largely interested in County as a source of political patronage? Is this because you do not know that Cook County Hospital is to all intents and purposes only an emergency and traumatic hospital? A hospital to which it is possible to gain admittance only if you have recently been injured or are suffering from some medical emergency? Is this because you do not know that "County" does not and could not provide adequate all around medical care for the medical indigent of our city? No one who reads the newspapers could be ignorant of these facts. Bob Freeark cannot correct these inadequacies alone. They must have our help.

What needs to be done? First we must recognize that we need Cook County Hospital, but that it must be a good hospital

—a better hospital. This will never be an accomplishment until the hospital is taken out of the hands of the politicians. But, as you say, "How can this be done"? It can be done in the same way that our school system was taken out of the hands of the politicians. You may say, "Oh, but our school system is far from perfect and full of problems." And you will be correct. Never suppose that because the situation at "County" is improved that it will be perfect. The first step must be to place "County" under the control of a County Hospital Board composed of public spirited citizens, not politicians, comparable to our Chicago School Board. Second "County" must be renovated and modernized both in its physical plant and in its administrative and medical organizations, until it provides the best possible medical care and the best possible teaching programs for the training of young physicians and nurses. Third, it must be recognized that "County" is already too big. For years we lived under the narrow minded dictation of the idea that Chicago could have only one municipal or county hospital. That idea must be changed!

Adequate Care

Adequate medical care in all of its phases must be made available to every citizen of Chicago and Cook County. If he cannot obtain such care or cannot afford such care he belongs with the medical indigent. And such care must be made available to him. This cannot be just hospital care. Many people who are sick and cannot obtain adequate care do not require hospitalization. In fact, hospitalization could be avoided for many of them if such home care or outpatient care were provided promptly. How this could best be done should be determined by a group of public spirited citizens working with the help and guidance of a public spirited medical profession. There are obviously several ways in which this desirable end could be accomplished. But no one could reasonably say that in Chicago, with all its doctors, its five medical schools, their thousands of medical students and with our hundreds of interns and residents, that this could not be done. What is needed is the will and vision to do it. In a city the size of Chicago it is ridiculous to have most of the public medical and hospital care centered

at one point in the city. Our medical schools are relatively widely dispersed. City hospitals organized and operated by these medical schools and with adequate clinic or outpatient facilities would go a long way toward meeting the needs of the city's medical indigents and toward improving the quality of medical education both at the undergraduate and graduate level. If those responsible for the political organization of the State of Illinois and of Cook County do not have the vision or the ability to do this then it should be done by the City of Chicago. It is obvious that Mayor Richard Daley who has done so much for this city, who has reorganized our school system, who has reorganized our police department to where it is recognized as one of the best in the world, can and will do it if the medical profession provides him with the proper guidance and incentives. This is our responsibility. We have neglected it too long.

Other Problems

And there are other problems. For years it has been well known that Chicago is woefully backward in the matter of transportation of the ill and injured. For years the Institute of Medicine has tried unsuccessfully to do something about this. I regret that at one time I was chairman of one of its committees that failed. I also know that the Trauma Committee of the American College of Surgeons under the direction of Dr. Sam W. Banks has worked hard to improve the deficiencies of our police and fire departments' ambulances. But not enough has been done. What is our ambulance service in Chicago? It is primarily composed of three parts, the biggest of which is the private ambulance companies which transport those sick and injured who are able to pay. These ambulances are staffed by crews that know little more than how to turn on a siren and run through traffic signals, but almost nothing about how to care for the patients placed in their hands. Another ambulance service is that of our fire department. This has probably the best ambulance crews available in the city. Dr. Sullivan has done a yeoman's job in getting this service developed—it presently has 25 ambulances available 24 hrs. a day. But this service is designed primarily to care for injured firemen and serves the public primarily in the event of some street or other public ca-

tastrophe. The third is our police squad-rolls. This is manned by well-intentioned police officers who are largely untrained in the care of the sick and injured. What we need is an adequate single public ambulance system capable of taking care of anyone, anytime, anywhere. What of helicopters? We know that they have been most effective in saving lives in Viet Nam. We know that they have been discussed extensively with our city officials and our hospital staffs but what has been done? Other countries have used these most advantageously. The Army utilizes its helicopters to transport patients to hospitals from out of the way places in backward Malaysia. Ireland uses them to transport the victims of highway and other accidents. **Why not us?** (*Ed note: The Chicago Fire Department does utilize helicopters in an ambulance capacity.*)

Obviously the City of Chicago badly needs to reorganize the transportation of its sick and injured. The medical profession, who of all its citizens should be most cognizant of these deficiencies, should insist upon this and offer its help and guidance in achieving the best possible solution to this problem. The personal interests of the private ambulance services and the interdepartmental jealousies of the fire and police departments must not be permitted to prevent this development as they have done until now.

And there are other problems. What has been done to establish continuing education of our profession? Enough? No! Are you waiting to be pushed into the undesirable situation of re-examination and relicensing of the medical profession at regular intervals? If you are not, then act before the politicians take over. We must follow the excellent example of the American Academy of General Practice and insure that *every* physician allowed to continue to practice is provided with the opportunity to up-date his knowledge regularly and that he takes advantage of these opportunities. If we do not do this then some outside agency will do it for us—and we won't like it.

Internship and Residency Training

What are we doing to insure that the internship and residency training in our hospitals is as good as it should be? There is a constant wail from non-teaching hospitals that they cannot obtain adequate staffs of interns and residents. Do they de-

serve to have them? Are they treating internships and residencies as educational opportunities, or are they only anxious to obtain interns and residents to have additional pairs of hands, and coverage for their emergency rooms? I know that there is a great variation among hospitals in this regard, but I also know that we are not doing the best job that could be done. The medical staff of every hospital that accepts interns and residents should sit down and ask itself what it can and should do. In all too many of our non-teaching hospitals the resident staff is composed largely of men from outside this country. These men come here to learn the best in American medicine. Are they seeing and learning the best? All too many of them find themselves merely being "used," not being taught. Many of them are returning to their homes disappointed and discouraged. This, unfortunately, is a sad reflection not only on American Medicine but upon the United States itself. In years gone by many of us, including LeRoy Sloan, profited greatly by training in other countries. Usually we were given the opportunity of seeing and learning the best that England, Germany, Austria, Switzerland, Scandinavia or France had to offer. It is our duty and responsibility to return this favor to the young men who now come to us from abroad.

Do I have an axe to grind? Yes, I have one. For years I have been concerned by the fact that civilians in this country paralyzed by injury to their spinal cords could seldom obtain good care and never the best care that is now possible. This is a national disgrace. Other countries have done far better. England, with all of the inadequacies of its national health service, has done far better. For the past 25 years England has had a Spinal Cord Injury Center at Stoke-Mandeville Hospital in Aylesbury. This 230-bed hospital is prepared to admit any one with a spinal injury at any time. They are prepared to offer him the best possible care immediately and to rehabilitate him so that in a few months he can return to his home and his job. Over 85% of the patients discharged from this center are today employed.

The complications which we in this country have all too often come to accept as inevitable—pressure-sores, infected bladders and kidneys, contractures—are avoided

in England. Nowhere in this country, with the exception of the recently established spinal cord injury center at the Massachusetts General Hospital, are we able to provide this kind of immediate service. To be sure, we have rehabilitation centers for these patients. But we do not have centers for acute care, and adequate care can only be provided in such centers. In such centers the complications usually associated with paralysis from injury to the spinal cord can largely be prevented, rehabilitation can be started sooner and in most instances the paraplegic can be discharged to his home and to his job in three or four months and the quadriplegic in six to eight. If re-education for a new job is required the time will be somewhat longer. Today our rehabilitation centers such as the excellent one here in Chicago and many elsewhere are doing a splendid job, but they are wasting weeks and months and thousands of dollars correcting complications which need never have developed. During this time these complications are preventing them from getting on with the job of rehabilitation. This problem will never be solved until we in this country follow the example of England and 19 other countries in establishing adequate spinal cord injury centers where these patients can be admitted *immediately* after injury and where they can receive the best care which we now know how to provide. Injury to the spinal cord involves our youngest and most vigorous young people—men and women between 18 and 25 years of age. It is a national, not a regional problem. It can be attacked only on a national basis. Outside of the victims themselves, the medical profession is the group most familiar with this problem. What is it doing about it? What is our country doing about it?

Our Gravest Problem

What is the gravest problem confronting our hospitals and our hospitals' patients today? It is not the need for more physicians. It is not the need for better treatment. It is not the need for more hospitals and more hospital beds. Great as these problems are, it is the need for more nurses and better nursing care. Of all people certainly the physicians are most aware of this need. What have they done about it? They have allowed the "nursing estab-

lishment" to ruin nursing, that is what they have done. They have seen nursing school after nursing school closed, and have done nothing about it. They have seen the nursing organizations ruin nursing education and done nothing about it. Nursing education has gone off in exactly the opposite direction from medical education. In medicine we have realized that to make good doctors we needed more and more bedside education. We have brought our medical students into closer contact with our patients and for longer periods of time. We have been and are creating better doctors. Nursing has done the opposite. They have developed more and more class-room, didactic teaching and removed the student nurse from the bedside and the patient. They have even removed nursing education from the hospitals, while in medicine we have moved more and more into the hospitals. They have removed the student nurse from all responsibility while in medicine we have realized that the student learns best when he assumes all the responsibility that his training and ability will allow.

The "nursing establishment" has been endeavoring to improve the status of the nurse—all power to them. Their status should be improved. But they have foolishly placed their confidence in improving status on academic degrees—the Bachelor's Degree, the Master's Degree and the Ph.D., instead of upon knowledge of and accomplishments in nursing. Heaven knows I have no fault to find with higher education or with academic degrees but they are not and never can be substituted for professional excellence, and professional excellence can only be gained by training and experience in the care of patients. Nursing educators state that nurses wish to be masters of their own destinies, and nurses should be. But today the control of their destinies and of the future of nursing education and of nursing is in the hands of administrators and bureaucrats who have little or no interest in or knowledge of nursing. The practicing nurse has nothing to say about the destiny of nursing or of nurses.

The Nursing Shortage

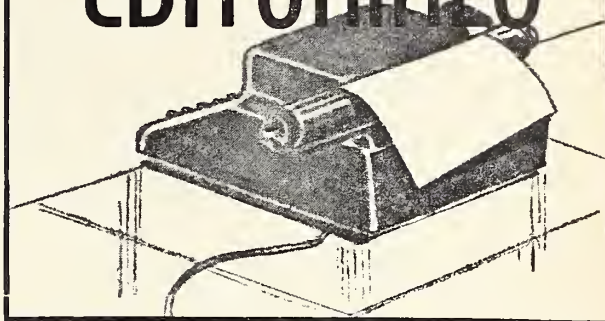
What about nursing itself and the shortage of nurses? No nurse enters nursing because of the financial remuneration. Fortunately young women are idealists, they want to help suffering and helpless people.

They enter nursing to take care of patients, not for the money involved. But in today's world, money cannot be ignored. In an era when business and industry are competing with nursing for the services of these young women, we must enter the market place.

Until recently nursing was woefully underpaid and in spite of recent increases in salaries it, in many respects, still is. In what other field of activity are people expected to work overtime and not be paid for it? Yet this is true of most of our head-nurses and supervisors. In what other occupation are people expected to work week-ends or nights without receiving time-and-a-half or double time pay for their work? How many of you would turn heavy helpless patients, cleanup filthy messes, listen to the whining, inconsiderate complaints of the sick, day after day for the salary that we pay nurses? How can we hope to compete with industry and business for the services of these young women when nursing has no system of pensions for retirement to compare with what is available outside of nursing? Could you save for your old age on the income a nurse receives? What are we as a profession doing to secure beds that will turn patients electrically, and to provide all other necessary means to lighten the heavy physical burdens of the nurse? What are we doing to lighten their other burdens and make their lives happier and more pleasant? Ladies and gentlemen, it is already much too late. We had all better start and help nursing to achieve the destiny of a respected and honored profession devoted to the care of the sick. Under the present organization nursing is a rapidly disappearing profession. If something is not done, done drastically and quickly we shall shortly find ourselves with the oriental system where each family moves into the hospital to care for its own relatives—and what an inadequate mess that is!

But it is time to stop discussing individual problems, important as they are. We of the medical profession must no longer limit our interests to providing the best medical care to our individual patients of which we individually are capable. We must interest ourselves now, and constantly in the future, in bringing the best possible medical care in all its aspects to everyone who needs and wants it. LeRoy Sloan would have wanted no less. ◀

EDITORIALS



EMERGENCY SUPPLY OF RABIES VACCINE

Rabies vaccination is a process of active immunization which requires 10-14 days for the appearance of demonstrable serum antibodies. At the same time, rabies virus can be demonstrated in the central nervous system within a few days after exposure. As a result, it is imperative that if vaccine is to be administered, it should be initiated without delay. The decision to vaccinate or not to vaccinate should be made on the basis of species of biting animal, prevalence of rabies in the area, whether or not the bite was provoked, clinical status of the biting animal, anatomic site of the bite and the age of the victim. Once vaccination has been started, the series can be stopped if developments suggest the biting animal was not rabid. Only rarely will additional information become available which suggests that vaccine should have been administered.

The Illinois Department of Public Health supplies ultraviolet irradiated rabies vaccine of rabbit brain origin for administration to Illinois residents. Each physician requesting state-supplied vaccine is requested to submit information concerning the circumstances surrounding the use of the rabies vaccine. Results of this work suggest that a major problem is the interval

between exposure and administration of vaccine.

There are numerous factors responsible for delays in the administration of the first inoculation. These include a patient delay in consulting the physician, physician delay in ordering the vaccine, and the problem of procuring the vaccine at the time it is needed. In an effort to reduce this last factor, the Department has recently distributed a 7-dose package of rabies vaccine to selected hospital pharmacies throughout the state. This distribution makes it possible for physicians to obtain the vaccine 24-hours a day, 7 days a week, at locations within convenient driving distance of most communities. The remainder of the series can then be ordered through the regular health department channels without delaying the immunization procedures.

Copies of the leaflet entitled, "Recommendation of the Public Health Service Advisory Committee on Immunization Practices" can be obtained from your local health department or the Illinois Department of Public Health, Room 500, State Office Building, Springfield, Illinois 62706.

Norman J. Rose, M.D.

OLD WIT

Medical jokes have changed considerably over the years. In the past they were concerned with horrible remedies, common mistakes, and the inevitable—death. Exposing a quack in court or during a consultation could be humorous and somewhat corny. According to an old book on wit and

humor, "A quack had instituted suit to recover his bill for medical services rendered. The defense was quackery and worthlessness of the services rendered. The doctor went upon the witness stand and was subjected to a rigid cross-examination as follows:

"Did you treat the patient according to the most approved rules of surgery?"

"By all means—certainly I did."

"Did you decapitate him?"

"Undoubtedly I did; that was a matter of course."

"Did you perform the Caesarean operation upon him?"

"Why, of course; his condition required it, and it was attended with very great success."

"Did you then subject his person to autopsy?"

"Certainly; that was the very last remedy I adopted."

"Well, then, doctor," said the counsel, "as you first cut off the defendant's head, then dissected him, and he still survives it, I have no more to ask; and if your claim will survive it, quackery deserves to be immortal."

On another occasion, Dr. Chapman of Philadelphia, a very reputable physician, was vacationing in the country when he was called into consultation by Dr. Jonson, a rural physician, who never had a regular course of medical instruction. Dr. Chapman knew he was a fraud and began:

"Have you used depletions?"

"No, sir," said Jonson; "I have thought of that, but it is not to be had out here in the country."

"Perhaps you have tried venesection?"

"I have not; indeed, it has never been introduced among us here."

"Then I would recommend phlebotomy," continued Dr. Chapman.

"The very thing I was going to give him as soon as I could get some of it from the city. You didn't happen to bring any with you, doctor, did you, sir?"

The Philadelphia doctor could hold in no longer. He laughed so heartily that Jonson insisted on an explanation and when he learned that the three suggestions amounted to the same thing, and that was bleeding, he bolted out, drawing his recovering patient along with him. The story got out also; and Jonson went by the name "Phlebotomy" to the day of his death.

And so it goes. At the end of the chapter, we found the story about an Irish doctor who sent the following bill to a lady: "To curing your husband till he died." (WIT AND HUMOR OF THE AGE. Star Publishing Co., Chicago, Copyright 1883 and 1901. Exposing a Quack [David Paul Brown] pgs. 430-431. *ibidem.*: Dr. "Phlebotomy" pgs. 434-435.)

T. R. Van Dellen, M.D.

IDPA Announces Fee Re-evaluation

In accordance with the agreement between the Illinois State Medical Society and the Illinois Department of Public Aid, fee charges by individual practitioners have been reassessed on the basis of the past two years of operation.

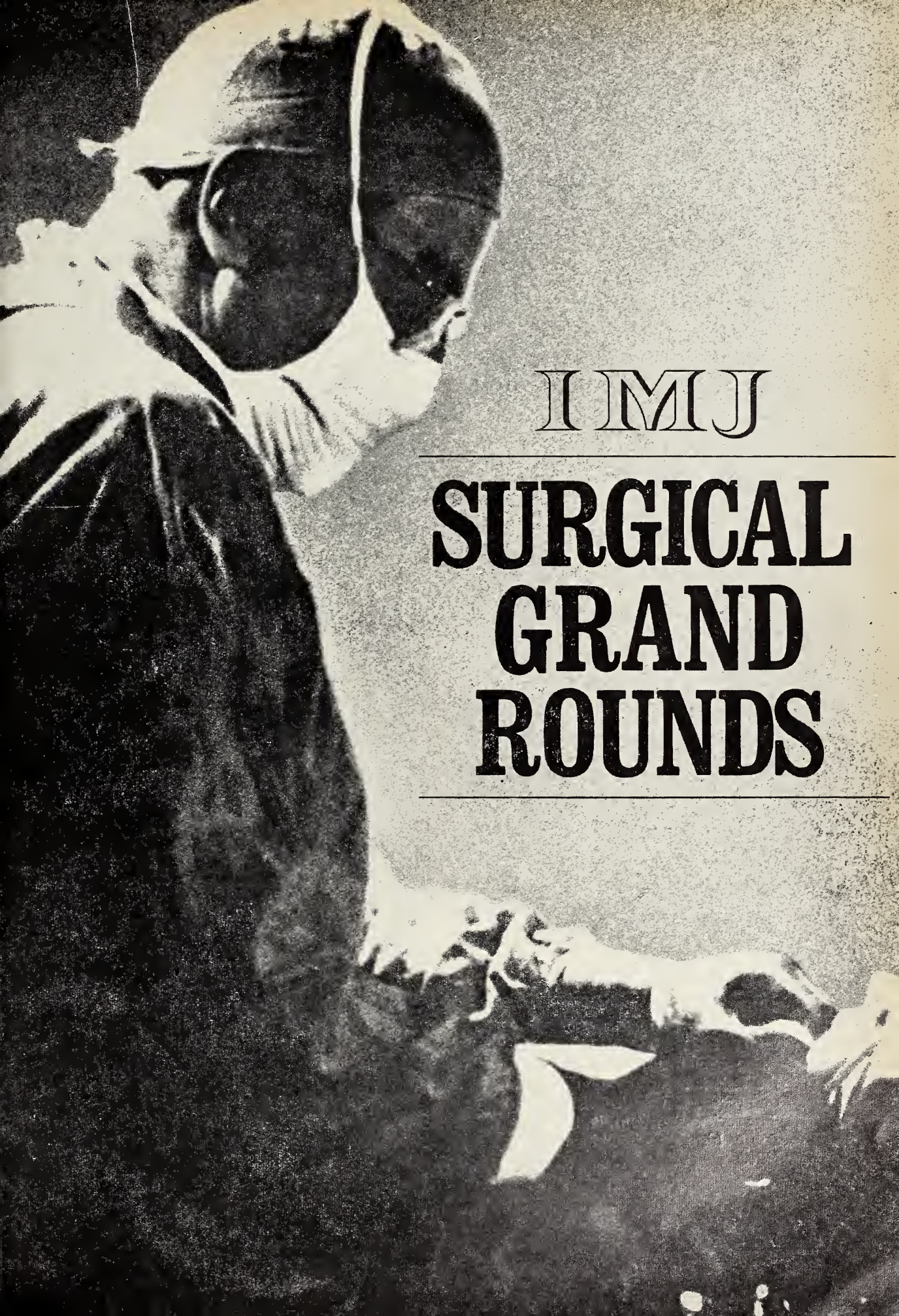
As a result of this review the Department will immediately begin to process bills for many procedure codes in many areas throughout the State at a re-evaluation of the updated prevailing community rates. Previous rates used were based on fees in effect in the fall of 1966 and this revision is primarily an updating of the "cost of doing business."

The announcement by the Illinois Department of Public Aid should not be considered as an indication that the new de-

termination of the prevailing rate will result in increased payments to every physician for every procedure code. The revisions primarily affect some 30 counties and relate to the most common procedure codes including routine office visits, initial and subsequent hospital visits, etc.

The Department again emphasized in their release of this information that the prevailing rate in a geographical area which provides for accessibility to a percentile of participating practitioners is still governed by directions from the Department of Health, Education, and Welfare in accordance with their directives to Medicare and Medicaid intermediaries on June 30, 1969.

A taxpayer is a person who can work for the government without taking a civil service examination.



I M J

**SURGICAL
GRAND
ROUNDS**

"Pasteurella Multocida"

Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m., alternating between the Staff Room at Chicago Wesley Memorial Hospital and Offield Auditorium at Passavant Memorial Hospital. Patient presentations from these hospitals and from Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on December 13, 1969.

EDITED BY JOHN M. BEAL, M.D.

CASE REPORT:

Dr. George Case: This patient, a 45-year-old white woman, was in good health until September 17, 1969, when she was scratched by her cat on the lower anterior medial aspect of her left leg. She was treated in the emergency room of Passavant Memorial Hospital, where tetanus toxoid booster and intramuscular penicillin were administered. During the next two weeks, the site of the scratch became progressively more erythematous and painful. She was examined again October 1, 1969, and was treated with warm soaks and Betadine with some improvement. She was admitted to Passavant on November 12, 1969.

She denied chills or fever associated with the lesion. A history of diabetes mellitus or peripheral vascular disease was absent. The review of systems, past medical history, family history and habits were unremarkable.

Physical examination: temperature, 98.6° orally. The general physical examination was unremarkable except for the left lower extremity. Examination of the left leg revealed a 2 cm. x 2 cm. x 0.5 cm. ulcer just above the medial malleolus, with some granulation tissue in the base but without grossly purulent material. There was minimal retromalleolar edema below the lesion. Inguinal lymph adenopathy was not present. Blood count and urinalysis were within normal limits.

Cultures of the wound were obtained and the patient was treated with moist saline soaks to the leg and frequent local debridement. On November 17, 1969, multiple punch biopsy grafts were taken from the lateral thigh and placed over the ulcer. She was discharged on November 19, 1969. Cultures revealed *Pasteurella multocida*.

Dr. Richard Geier: The second patient is

a 42-year-old white man who was bitten by his own cat while breaking up a cat fight on October 13. The cat was impounded and has remained well. Two days after the bite, the man had some soreness in the area of the bite. He went to his doctor and received a tetanus toxoid injection. Two days later, he noted pain and swelling in the area, which was on the posterior aspect of the lower part of the right leg. He returned to the doctor five days after the bite and was given an anti-inflammatory agent. Following this, he developed a fever, as high as 103°, and was confined to bed because of fever and extreme pain with any type of motion or attempt to walk.

He was admitted to Passavant October 26, thirteen days following the bite. He had spontaneously drained a small amount of bloody fluid from the areas of the bite before admission.

When examined, the patient was healthy appearing but with obvious pain on any movement. The right foot and the lower three-fourths of the right leg were swollen, erythematous, tender and warm. There was purplish discoloration around two small, oozing points on the posterior medial aspect of the leg. Temperature was 100.6° on admission.

Cultures were taken and the patient was treated with penicillin and moist dressings. Three days after admission, he became afebrile.

On November 2, the draining sites were probed and it was found that a hemostat could be inserted into a fairly large cavity on the posterior part of the calf. Culture of the draining site showed a heavy growth of *Pasteurella multocida* that was sensitive to several of the broad-spectrum drugs. Ampicillin was selected for treatment. The following day, a large abscess cavity was incised and drained, and a quantity of foul-smelling, necrotic, infected muscle, fascia and subcutaneous fat was debrided.

His course was now one of steady improvement. The wound began to granulate satisfactorily. He had developed a contracture of the gastrocnemius muscle, which delayed grafting while physical therapy was instituted. Skin grafts were applied November 28, and his leg was encased in a short cast. Following the removal of the cast, he has resumed his physical therapy and is able to walk reasonably well.

Dr. Franklin Lounsbury: The second patient presented several problems in management. I was struck initially by the fact that the wound drainage was so bloody. When the drainage appeared to be inadequate and the two draining ulcers were connected, a surprising amount of necrosis of the deep tissue was found.

Dr. Julius Conn: I was amazed by the time sequence of these leg ulcers. The first patient came to the emergency room 5 days after being scratched. At that time she had what looked like typical cellulitis. Antibiotics were prescribed and within three days, the cellulitis had subsided. A small eschar was present at the site of the scratch that gradually ulcerated. Over a two week period the superficial ulcer became progressively deeper in spite of careful wound care.

Only after entering the hospital and being given Polycillin did this patient's ulcer cease to drain. The ulcer over the malleolus was then closed with multiple punch grafts. She has now developed a second small punched out ulcer posterior to the original one which is responding to broad-spectrum antibiotics and local wound care.

Dr. John Beal: There are specific reasons for presenting these cases. These patients developed serious problems that had rather innocuous beginnings. The importance of adequate wound culture in patients who have wound infections, even some that seem to be relatively minor, is stressed in these cases.

Dr. Sommers of the Department of Pathology has had a particular interest in infection and in the detection of the causative organisms in indolent infections.

Dr. Herbert Sommers: The organism isolated from these two cases illustrates the rather serious complications that can occur from *Pasteurella multocida*. The man has now been sick for six weeks or more and the woman similarly, for six to eight weeks, with chronic, non-healing, progressive infections. Because of the serious nature of the infections, we would like to discuss these cases and illustrate how the clinical diagnosis can be made on the history.

The genus *Pasteurella* are a group of organisms which include *P. tularensis*, *P. pestis* and a number of other very pathogenic species. *Pasteurella pestis* is associated with true pathogenicity as is known from

history when, during the Great Plague, large segments of the European population were wiped out. The particular organism we are going to talk about is really an organism which has been associated with a number of names, depending upon the animals parasitized. Louis Pasteur in the early 1880's first identified an organism which was associated with fowl cholera. Actually, we now know that there are two kinds of fowl cholera but at that time it was thought only *Pasteurella multocida* was the etiology. A similar situation was soon recognized in cattle and was known as shipping fever. This was associated with hemorrhagic infections causing death of the cattle which, of course, were food and therefore presented a severe economic burden to the world's population. This organism was called *Pasteurella bovisseptica*. Hog cholera, presenting in pigs, was called *Pasteurella suisseptica*. When all three of these organisms were studied together, they were found to be remarkably similar, both culturally and antigenically and, as a result, they have been lumped together in a group called *Pasteurella multocida*, or "many killing."

Remember, the first groups of these were described in about 1878, which was soon after Pasteur started his work. This is in some contrast, I think, to the fact that not too many physicians were aware of this particular organism, its significance and some of its identifying characteristics until the past five, ten to fifteen years.

In humans, *Pasteurella multocida* is usually seen in three clinical patterns. The first is a local infection, which may be associated with lymphadenitis. This is most commonly associated with cat scratches or cat bites. I think it important to emphasize that *Pasteurella multocida* is not the same agent which is associated with cat scratch fever. As yet, the agent of cat scratch fever has not been satisfactorily characterized.

Pasteurella multocida, which may present as a chronic, progressive, ulcerative lesion, is most commonly associated with cat scratches and cat bites, although it is also seen in dog bites and bites from lions, panthers and other animals.

The second form of infection with *P. multocida*, of which we have not seen too much in this country, is chronic pul-

monary infection. This has been seen more commonly in England. These infections are usually associated with patients who have some debilitative pulmonary disease, such as emphysema, bronchiectasis, or one of the pneumoconioses. Pulmonary infections may be associated with chronic disease or may present as an acute abscess. In one instance, a *P. multocida* infection was associated with perforation of a major pulmonary blood vessel with exsanguinating hemorrhage during bronchoscopy.

The third type of infection seen with *P. multocida* is a diffuse septicemia. Wound infections may progress to septicemia. It is also associated with meningitis, having a very high mortality rate. Clinically, infection with cat bites is rather common, but fortunately septicemia is not. In few cases do patients who develop meningitis and septicemia have only a history of association with some animal.

There are certain characteristics about local infections which are illustrated very well by these two cases. Frequently, the actual signs and symptoms do not occur within the first few days. In time, the infection may become chronic but progressive. They do not always respond to the time-honored hot soaks, elevation and conservative therapy that most of us like to see used first. They do have a tendency to be indolent, to be associated with fever, ulcerate, and produce considerable necrosis. Frequently, as illustrated in these two cases, the extent of the infection is inapparent initially but, with direct examination, there is usually considerable underlying necrosis. Local infection may be associated with direct penetration and necrosis to the tendon sheaths and bone, producing osteomyelitis in the underlying area. Infections with *P. multocida* characteristically show a direct penetrating pattern which is probably associated with poorly understood toxins. In animals, *P. multocida* produces hemorrhagic lesions and may give a similar pattern in humans. It is of interest that there was hemorrhagic drainage from the wound in one of the cases described here.

Where is the natural habitat of these organisms? A group in Norway found *Pasteurella multocida* in the nasopharynx of 15% of rats. Normal cats have been found to harbor this organism in their nasal pas-

sages and oropharynx in up to three-quarters of the animals surveyed. This is not associated with clinical disease in the cat. The organism is apparently a commensal in the cat and only causes disease when introduced into a susceptible host, such as man. Dogs have been found to harbor the organism in about 60% of those surveyed. Certainly, a higher percentage of *P. multocida* infections develop following cat bites than dog bites. The virulence of lion, tiger or cat bites frequently is associated with a chronic, penetrating, progressive, necrotizing infection which, in many instances, is due to *P. multocida*.

Surgical treatment is frequently necessary for the complications. Both of these cases have illustrated the need to incise, drain, and to allow for more adequate treatment, including skin grafting.

In addition to surgery, the patient should be treated with antibiotics. Although most of these patients were treated with antibiotics initially, the amount and the time for which they were given were inadequate. Larger amounts have to be used for prolonged periods of time. If the organisms are tested for antibiotic sensitivity in the laboratory, they are usually quite sensitive to penicillin. It must be given in large doses over a long period of time.

The fact that not many physicians are familiar with *Pasteurella multocida* probably reflects that we haven't been very good in our ability to identify and characterize the organism. One important aid to the laboratory is the history of an animal bite. For example, we picked up the first one as a growth from a wound culture and then found out it was a cat bite. In the second case, we asked Dr. Conn if the culture from his patient was from an animal bite and he said a cat scratch. Any information that you can give us as to the location of the wound and as to the circumstances of the infection can help us in terms of plating the culture on different media for optimal recovery. Any information you can give us is going to help in terms of the recovery and identification of specific pathogens. *P. multocida* infection is a classic example. We hope before too long to have a rather sophisticated system of anaerobic bacteriology in use. This will be of particular use to surgeons because wound cultures, particularly those in the abdominal and lower portion of the body, are

prominently associated with anaerobic bacteria. However, because of their varying tolerance to oxygen, such organisms have to be cultured immediately. If you can get the clinical specimen to us immediately, we are going to be able to give you a good deal more in the way of recovery and information on bacteria in these wounds.

Dr. Beal: Dr. Sommers, are special culture techniques required to detect these organisms?

Dr. Sommers: We do have, at the present time, a procedure for taking pieces of tissue, homogenizing and putting the specimen out on about 12 to 14 different types of media. Hopefully, this will include a broad range of organisms, such as fungi, anaerobic organisms, and tuberculosis. The more tissue you can send us, the better. Small amounts of pus are really better than swabs. Two or three swabs are much better than one swab, as we can take each swab and use it for different media that might destroy further usefulness. It is necessary to inoculate many media as fungi grow differently from bacteria, anaerobic bacteria grow differently from aerobes, and so forth.

Again, the more information we have on the type of specimen, the better we can culture for specific organisms that might not have occurred to you. Adequate information, at least two to three swabs and one or two smears are preferred. More than one smear allows for staining of the specimens by many methods, not just a gram stain. If we find everything we are looking for on one smear, we can throw the others away. If we don't there is the added insurance that we will be able to carry out other stains if our initial smear does not offer an adequate explanation. If any of you have any questions or problems concerning how to collect clinical specimens, please call me.

Dr. Stuart Poticha: Are *Pasteurella* organisms likely to be detected by routine culture methods?

Dr. Sommers: In the case of *Pasteurella multocida*, yes and no. Yes, as we were able to get almost a pure culture in one case, but there may be contamination with other bacteria which might obscure *P. multocida*.

Dr. Beal: This suggests the need for getting an additional culture if the course of the patient is unusual in the presence of

infection of the skin and subcutaneous areas.

Dr. Sommers: That's true. The other aspect we haven't touched on here is superinfection. There may be an initial staphylococcal infection which can be controlled with a particular antibiotic; this may in turn be followed by a pseudomonas infection. So that, if wounds do not recover as you treat them either by antibiotic or by local means, please submit additional cultures. Sometimes, when this is done, we get the same organism down day after day. I don't think it necessary to have a whole series of cultures day after day but properly spaced cultures may well show a change in flora. This can be of help in handling the patient and selecting therapy.

Dr. Herold Griffith: It was mentioned that the majority of cats have these organisms in their mouths. Yet, the great majority of cat bites do not develop this type of infection. I think one of the reasons for this is the initial treatment. Inasmuch as antibiotics are not always reliable in these cases, it would appear, on the basis of what we have seen, that really thorough excision of the wound is essential—not just rinsing it out and nipping away ragged pieces of tissue on the sides, but actual total excision of the wound. Obviously this must be done very carefully to

avoid undue sacrifice of important structures, especially about the face and hand. It may be necessary to use a skin graft at the time of initial treatment. In the case of a large wound, excision, packing and delayed primary suture may be desirable.

We had an instructive case recently. A young woman was bitten on the finger by her cat. Within a matter of hours, she was seen in the emergency room; the wound was cleansed and a Band-Aid was put on; she was given tetanus immunization and sent home. No antibiotics were used and no other treatment was given. Within 24-hours, she had a fullblown acute tenosynovitis involving the entire tendon sheath. We admitted her to hospital immediately, fully expecting to have to perform incision and drainage. Fortunately, antibiotics, warm soaks and rest made drainage unnecessary and within about three weeks she had full range of motion of the finger. This infection could probably have been prevented by more thorough initial treatment.

It must be remembered that all bites, be they from cats, dogs, humans or whatever, are contaminated with bacteria, which are potentially dangerous. Meticulous early care of the wound and the use of antibiotics are essential if serious infections are to be avoided. ◀

Genetic Transformation

Genetic transformation, the replacement of a gene or set of genes for another, is one of the ways in which heredity can be controlled. Although geneticists cannot yet mold human progeny, they can control some aspects of bacterial heredity, according to molecular geneticist Arnold W. Ravin.

Ravin, Professor of Biology at The University of Chicago, can determine successfully the genetic fate of unborn bacteria by injecting normal, bacteria cell cultures with genetic material extracted from bacteria which have acquired, by mutation, a resistance to antibiotics such as streptomycin and erythromycin. Bacteria growing from cultures receiving the genetic material, deoxyribonucleic acid (DNA), from resistant bacteria also become resistant to antibiotics.

Ravin said transformations provide a way to study the chain of events underlying the passage of genes from one cell to another, but they have numerous medical implications as well.

For example, such transformations conceivably could someday correct genetic defects and the cellular malfunctions involved in such diseases as cancer and sugar diabetes. Also, knowledge of the control of transformation could result in improving the body's defenses to entry by undesirable agents, such as viruses.

"With few exceptions," he said, "attempts to produce transformation in higher organisms have not succeeded. However, we think that the possibility still exists, but the right conditions under which transformations can occur must be found."

Future Forensic Medicine in Illinois

When the physical life of a human being ceases, civilized people demand an explanation of the cause of death. A number of deaths—internationally estimated between 20 and 25% of the total—require thorough and complete investigation so that answers can be found for the questions "Who?, When?, Where?, and What?" This disserta-

tion is written to stimulate cerebration pertinent to the above, as well as certain constitutional changes that may be proposed in Illinois. The writer is an M.D. Coroner of over 20 consecutive years. Heading the team that performs the requisite investigation must be a well qualified member of the medical profession.

BY SAMUEL K. LEWIS, M.D./ELMHURST

Samuel K. Lewis, M.D., is Coroner, DuPage County and an Elmhurst general practitioner. A 1934 graduate of the Chicago Medical School, he is the former president of both the Illinois and International Coroners Associations and recipient of the 1968 "Coroner of the Year" award. Dr. Lewis is listed in *Who's Who in the Midwest* and is a contributor to "Coroners Corner" in *"Modern Medicine."* He has served as a coroner for 23 years.



Needed Qualifications

This physician—whatever his official title—must be adequately prepared professionally, ethically, physically and mentally. He must have an unwavering desire to better the lives of his fellow men. He must be a keen observer. The work demands that he be able to gain the immediate confidence of all the other professional people in his domain. His temperament must be callous to all remarks that the press and his fellow citizens may make. To them, as well as to himself, he must be honest. He must never rebuff his critics by spoken or written word.

The medical administrator must teach and study. His working time is a 7-day, 24-hour-day week. He must teach all with whom he comes in contact. Because of his

observations he may instruct the hospital staff, the fireman, the Boy Scout, the nurse, and even the mother.

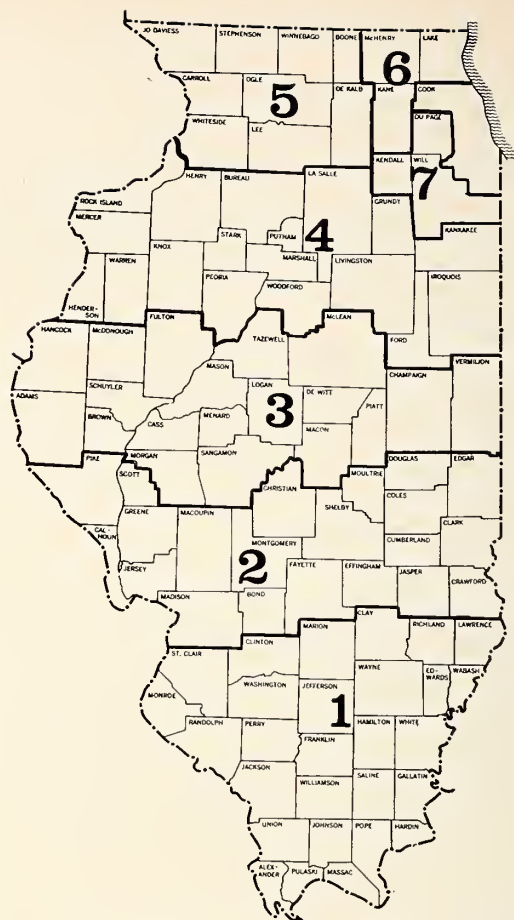
Teaching and study, of course, go hand in hand. The medical administrator will never see all of the known variations of the "cause and manner of death," but he should keep studying the fundamentals. It is therefore imperative that the medical administrator be an active member of his local, state and national medical organizations, and appropriate specialty groups. One of these is the American Academy of Forensic Sciences with its many subsections of Forensic pathology, psychiatry, and questioned documents.

The Necessary Number

What about the number of individuals who may be known as "Medical Administrators?" One physician can administer this work for a population of up to 700,000, *but not more*. Illinois and its cities may easily be divided into districts containing between 400,000 and 600,000 people without disturbing county boundaries. This idea is not unique. The States Attorney's Association of Illinois has sent a resolution to the State Bar Association outlining a similar proposal. Such an arrangement will give each medical administrator 600 to 800 cases per year. For this work load a beginning salary of \$25,000.00 to \$35,000.00 per year would be fair and adequate. Under the present "archaic" County Coroner regime the figure for the same number of people is well over \$100,000.00. Much of this is spent for worthless, inadequate fees of various assortments. The stipend the physicians would receive would be in addition to the allowances for traveling expenses and other reimbursements that are standard for governmental agencies in the area. The administrator would have no time for extensive supplemental private practice.

The money spent on this work should come out of the general tax funds because the outlays are for the good of everyone, and cannot be collected in an equitable way from individual estates.

If an inquest is necessary—and occasionally it may be—it should take place in formal court. The medical administrator and his staff should present their findings to a judge and jury, who may then arrive at the truth regarding related legal matters



Suggested consolidation of "down state" counties into districts for the medical administration of unusual deaths. The criteria below were implemented in the suggested districting.

1. Preservation of county boundaries.
2. Population distribution, including prospective growth.
3. A large city in each district.
4. Environmental and transportation problems, along with prospective caseloads.
5. The probable location of medical schools yet to be established.

other than the "cause and manner of death." The administrator should be prepared to defend his statements on cross-examination.

Finally, what authority should the medical administrator have? Authority and power are nebulous terms. Certainly he should have authority, with legal immunity, to do or order any type of examination of the scene, of the decedent or others involved that he feels would be useful in arriving at a correct diagnosis. Above all, there is no place in this work for a sneak play or an underhanded examination!

The foregoing recommendations are particularly applicable to Illinois at this time as an opportunity exists for a complete change.

New Plan Proposed

The new plan may include the establishment of a department at the University of Illinois. This new department should be staffed with young, highly educated, imaginative and dedicated individuals who will make it productive in the research area of Forensic medicine; will provide the state with an up-to-date progressive central crime detection pathology and toxicology laboratory that will turn out well qualified graduate students. Such a department could provide personnel for other states, too, for well trained specialists in this field are and will continue to be in great demand everywhere.

In this new department, studies of old and new cases, domestic and foreign, should be documented and computerized. Such a department should be a separate entity. It must have liaison with all the disciplines, including foreign language. Translators and interpreters in all languages are now frequently needed.

The Alaskans who have improved on the "Lower 48" think nothing of flying a corpse from the Aleutians to Anchorage—a distance of over 1,000 miles—for a complete pathologic, and other studies. There is an excellent department of this type at Case-Western University in Cleveland, Ohio.

Conclusion

The medical administrator must be non-partisan. He is a physician entering a new field. He should have formal pathology training even though he may have others on his staff who are certified specialists to assist him.

There is no necessity for a medical administrator in each county. Districts may be laid out so that less money expended per capita will provide more professional examinations and far greater educational and statistical efficiency.

A central point to call for help could well be a progressive Forensic Department at the State University which would issue a "Code of Procedures."

The medical administrator must have adequate authority and be adequately compensated. Fees of all types as well as regular inquests must be eliminated.

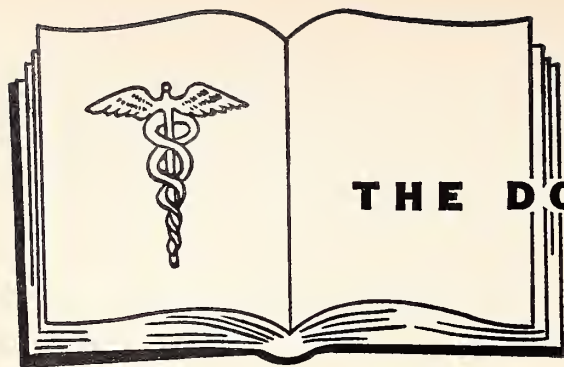
The types of cases to be called to his attention and the time element are proper subjects for discussion by the component medical societies. The medical administrator's work must not be limited to questions of homicide, suicide and accident. It should cover all unanswered questions of bacterial, therapeutic, chemical, thermal, thermonuclear, and mechanical hazards to human life as well as all those cases of sudden death not attended by a medical doctor.

A young physician who makes this his life work will find great satisfaction in the help he can give a deceased person's survivors to live more happily and healthily.

The Illinois State Medical Society, through its component societies may begin immediately on the revision of this archaic, inadequate link in law enforcement, i.e. the Illinois coroner system. The new system should be entirely medical and therefore must be sponsored by medicine. The selection of the administrators, the districting, etc. should all be in the hands of the State Medical Society Trustees. They would, of course, set up guidelines for both selection and dismissal. "Con-Con" will soon be upon us. Let us not keep the citizens of Illinois waiting another hundred years. ◀

Poverty Level Raised to \$3,600

The U. S. Labor Department has raised from \$3,300 to \$3,600 the level of annual income below which a city family of four is considered "poor" in qualifying a member as eligible for various government manpower programs for the "disadvantaged." For farm families, the level has been raised from \$2,300 to \$3,000.



THE DOCTOR'S LIBRARY

MORRIS FISHBEIN, M.D. (An Autobiography), Doubleday, 505 pages, \$10.

In 1962, at a large banquet honoring Dr. Morris Fishbein, I described him as "A many-sided man to many different people. Some consider him the voice of the American Medical Association; others look upon him as an author of medical books and health articles, a ruthless opponent of socialized medicine, a bitter foe of quackery, a controversial editor, or a physician who talks effortlessly on any subject that flits through his agile and retentive mind."

We have looked forward to his autobiography for firsthand information on the life and thinking of one of the most widely-known and influential physicians in America. Our expectations were not disappointed and, as an extra dividend, we found his widely diversified experiences so interesting it was almost impossible to put down the book. For the first time, the general public will have an opportunity to learn more about the man who often is described as a genius.

The book was published as Dr. Fishbein's 80th birthday (July 22) approached. The contents are not a compilation of random thoughts and reminiscing; Dr. Fishbein and his wife, Anna, kept diaries and programs of their activities. He reads 2,000 words a minute and has almost total recall of the material with his encyclopedic mind. He writes up to 10,000 words a week, and delivers 100 speeches a year, and talks with the speed of a machine gun. He has had to do this in order to accomplish all he has in 80 years.

His description of his work as editor of the *Journal of the American Medical Association*, is, in reality, a history of medicine in the United States. Many laymen know him best as editor of the popular *Modern Home Medical Advisor*.

The book contains many stories about

his work in corporate problems, games of golf, bridge, gin rummy, and poker. He enjoys art, literature, music, reading, and, above all, travel. In the book, he discusses his friends here and in London, Paris, Athens, Madrid, Amsterdam, Moscow and Tokyo. The autobiography provides evidence of his humor and quick thinking in emergencies. It also reveals his philanthropic and humanitarian deeds.

In addition to all of this Dr. Fishbein remains a loyal husband and a devoted father to his three children. Justin, his son, provides some insight about the family in his tribute to his dad and mother, who also gave top priority to family matters. "My parents are persons of action who teach by example. They rarely told us what to do and what not to do. Instead, we learned about life by keeping our eyes and ears open."

T. R. Van Dellen, M.D.

THE EVOLUTION OF PREVENTIVE MEDICINE IN THE UNITED STATES ARMY, 1607-1939, The Historical Unit, USAMEDS, Walter Reed Army Medical Center, Forest Glen Section, Stanhope Bayne-Jones, M.D., Superintendent of Documents, Government Printing Office, Washington, D.C., 20402. (1968) \$2.50.

THE EVOLUTION OF PREVENTIVE MEDICINE IN THE UNITED STATES ARMY, 1607-1939 is an historical narrative that brings together a wealth of enlightening information about the origins and developments of the main principles and practices of military preventive medicine and its relationship with civilian public health. The material was obtained from widely scattered and until now only partly explored sources.

It is a small book of 255 pages with 3 appendixes, 39 illustrations, and a comprehensive index.

T. R. Van Dellen, M.D.

Experience In Suicide Prevention

"Calls For Help In Chicago"

BY JAMES L. WILKINS, PH.D./TORONTO, CANADA

Those who attempt to prevent suicides, especially in the proliferating centers for suicide prevention, must assume enormous responsibilities with far too little information to guide them. Decisions about how to cope with individual patients, how to identify the various types of patients for whom suicide may be in question, and how best to organize their efforts to deal with these patients are agonizing. Because accumulated experience is the best guide upon which to base such decisions, what few professional records there are must be complete and accurate. The literature on suicide prevention centers is a promising source for data, but it includes an assortment of research findings, opinions and impressions from centers with little experience as well as from established ones.

The history and findings of the Chicago Call For Help Clinic are instructive on many questions vital in suicide prevention; they also dramatize the need for careful research to supplant judgments made on other grounds. It became clear in the Chicago center that a priori and early assumptions can be wide of the facts that are revealed through continued and stabilized experiences. Also, some beliefs derived from clinic experience with callers were discovered by systematic research to be unfounded. The more important of these propositions about suicide prevention center callers, and potential suicides in general, will be examined here, using data from the Chicago center and others.

Method

The Chicago Call For Help Clinic was operated by the privately funded Stone-Brandel Center. For the first year and a half, it accepted daytime telephone calls and referrals, most of which came from a small number of Chicago hospitals. On July 1, 1966, the Center initiated a 24-hour telephone service, using medical students as the direct contact night staff, with the day staff and other psychiatrists as backup personnel. (A full report of background information has been previously published.¹⁰) For most analyses in this paper a 10% random sample was drawn from the 2,050 cases received until September, 1967. The follow-up studies used all cases.

Phases of Development In The Center

Most suicide prevention centers begin with a more economical operation during the daytime hours, anticipating a 24-hour service. When that comes, however, it may be followed by a sense of "let down." Because the total volume of calls does not increase as much as expected, and because it seems that proportionately fewer of the clients who make contact with the night service are clearly suicidal, the "let down" is understandable.

In retrospect, this disappointment seems inappropriate, however. First, the shift from daytime to 24-hour operation was not merely quantitative, but one of character. During the daytime phase, staff members were gaining experience, studying the literature on suicide, and in other ways pre-

paring themselves for the shift to 24-hour service. Most of their patients were referred from Chicago hospitals which had pre-selected them because they were near-suicidal or had attempted suicide. The 24-hour service, however, depends not upon hospital referrals but upon publicity and general awareness in the community. The proportion of pre-selected cases drops off accordingly.

Secondly, the staff may regard the volume of calls as an indicator of success, and when the number of calls does not dramatically increase after the opening of the 24-hour phase, some disappointment should be expected. However, community awareness for an agency not yet in existence cannot be very widespread or effective. Thus, the early part of the 24-hour phase should be regarded as a time in which to make the service known, no matter how much effort was spent in publicizing the preceding daytime operation. At the Chicago center, the first six months of 24-hour operation averaged only 149 calls a month, or five a day.¹⁰ However, the number rose steadily, reaching a monthly average of 233 after 15 months.

The latter figure of 233 calls each month is quite close to that reported in other cities after approximately the same period—for example, 223 in Los Angeles after a year,⁴ approximately 202 a month for 23 months in Melbourne²—and it is considerably higher than in some other cities for which reliable reports are available (e.g., Miami,¹¹ Boston³ or Belfast⁵). It is usual to find that the volume of calls multiplies over the course of time, as the center becomes known.^{5,9,13,17}

To summarize, the early phase of a 24-hour suicide prevention center operation may seem disappointing: the patients may not seem to really need the center's services, and the volume of use may not meet expectations. Objectively, however, a daytime-only service is in many respects not com-

parable to the 24-hour telephone operation, and these centers build to a substantial volume only after an initial slow period during which they become better known in the community.

Change In The Suicide Rate

In the Chicago center and apparently in others,¹¹ the staff felt a change in the community suicide rate to be an important criterion of performance. From a practical or a methodological point of view, acceptance of this criterion is self-defeating. Particularly in the early stages of operation, when few people know of the center and few calls come in, it is unrealistic to seriously expect such results. Furthermore, suicide rates are affected by many variables other than the presence or absence of a center, and it would be all but impossible to isolate these in order to single out the influence of the center. Bagley, who has discussed some of the methodological difficulties in dealing with this question, applied an ecological design with data from several cities in an effort to approach a reasoned answer. He found that there may be reasons to think that the presence of a suicide prevention center is related to lower rates of suicide, but the question is by no means yet resolved.¹

There is a certain direct appeal in the idea that an effective suicide prevention center would reduce a city's suicide rate. On the other hand, for reasons such as those just reviewed, it seems logically and materially inappropriate to gauge the value of a suicide prevention center directly and simply by whether the suicide rate changes or not.

Suicide Among Callers

If the proportion of suicides among callers is about the same as in other centers, this may be taken to indicate that the center was used by suitable patients or that it failed to help the callers. If it is lower, this may produce the inference that the center has not been dealing with persons for whom suicide was genuinely at issue, or that it has been effective in meeting the needs of the callers.

Quite aside from the logic of these inferences, there certainly should not be any conclusion drawn without sufficient follow-up work to establish what the actual sui-

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cide rate among callers has been. Special efforts are needed to determine the number of suicides among callers, for there is no reason to expect that they would be reported to the center. Without this work, it was concluded in the first phase of 24-hour operation in Chicago that there had been no suicides among patients.¹⁰ The implication was drawn that the service was not used by truly suicidal people.

However, when a study was undertaken using records from the Coroner's Office, Vital Statistics and Board of Health records for the county and the caller population, the proportion of suicides was found to be similar to those reported for other centers.^{5,8,11,12,15}

The percentage of completed suicides among callers may be interpreted in different ways, and even if it had been lower in Chicago than in other centers it would seem unwise to conclude that the center had not been appropriately used. However, no interpretation should be ventured if the estimate of completed suicides is done casually, for most suicides will not be discovered without systematic work with death records.

Suicide Potential

After the Chicago center had been in 24-hour service for about six months, the professional staff felt compelled to conclude that the callers had been of low suicide potential.¹⁰ A "suicide potential scale" was used for a short time, but its reliability and validity were doubtful, and its subsequent abandonment testifies to its uselessness. Unfortunately, however, this left the evaluation of suicide potential to individual intuition.

In retrospect, the demoralizing conclusion that the callers were of low suicide potential appears to have been inaccurate. When the characteristics of the callers are compared to other research findings and vital statistics records on suicide rate, it is clear that the callers are certainly persons at advanced risk.¹⁶ The work required to make these comparisons is initially considerable, but the result of the effort is a correct conclusion, as confirmed by the follow-up study, rather than an incorrect one.

Emergency Intervention

The number of emergency interventions

which the center is called upon to make may also be considered an index of the success of the center in dealing with potential suicides. The percentage of calls which required intervention was very low during the initial phase of the 24-hour operations,¹⁰ but it rose ten-fold during the longer period of this study and became similar to that reported from other centers.^{6,14}

There were also several constraints upon the staff that depressed the number of interventions from that which might otherwise have been made. For example, the staff was not allowed to go to the patient, and at night the patient was not permitted to come to them. Some other centers operate differently. To draw any conclusion from the bare statistics concerning the proportion of emergency interventions it would be important to know about these operating procedures.

In summary, the proportion of calls receiving emergency intervention rises as the center becomes better known, and careful consideration should be given to what the operating staff is enabled to do. In Chicago, the disappointing conclusion that persons in greatest immediate need of help do not turn to the center was drawn both prematurely and erroneously.

Chronic Callers

One of the greatest concerns in the operation of the center was that a substantial population of chronic callers could become a drain upon the time and energies of the staff unless techniques were developed to discourage them.¹⁰ This is an understandable fear, probably accentuated by the shift from pre-selected patients to dealing with anyone who chooses to call. Additional anxiety could be expected due to the necessity to decide how and when it may be justifiable to discourage a caller. Unfortunately, there was no research on this matter at the center. Thus, the concern to discourage chronic callers was fitful and undirected by knowledge as to how many of them there were or how much of a burden they posed.

The present research indicates that this fear was greatly exaggerated. Further, some staff were intimidated and impaired in their work by this fear, and some callers were too quickly put off. The review of the case files shows only 2.5% of Chicago

callers made six or more calls, and only 1% were designated as "chronic." This is not much different from the published data for other centers, which report between 1% and 4% of their callers to be "repeaters."^{2,7} Moreover, the majority of Chicago repeat callers called only two or three times.

Farberow, Shneidman, Litman and others connected with the Los Angeles center have observed that "the chronic case . . . is frequently, sometimes continuously, suicidal [presenting] the community with one of its most challenging problems."⁴ They are often persons who have exhausted the other sources for help in the community and turn to the center hoping for something more than just another referral.

Perhaps the most impressive datum concerning chronic callers in Chicago is that while only between 1 and 2.5% of the total number of callers were either designated "chronic" or called six or more times, the follow-up study of callers showed that about half of the callers who committed suicide belonged to this grouping.

It seems that concern about chronic callers is misdirected if these people are thought to be a nuisance population, best discouraged from further contacts. First, they are a very small proportion of the total number of callers, even though they become salient because they turn to the center more than once. Perhaps more importantly, they are remarkably more likely to be in need of help otherwise unavailable to them and are more likely to commit suicide.

Conclusions

Certain factual errors and misconceptions plagued the work and hampered the morale of the staff in the Chicago suicide prevention center. Rectification of these errors and misconceptions would be helpful to anyone who deals with potentially suicidal people and, even more directly, should aid other programs for suicide prevention. To avoid repetition of these errors, the following findings should be considered:

1. Use of a 24-hour suicide prevention telephone service is low initially and the problems presented to the daytime clinic by hospital referrals seem more serious. However, the latter comparison is specious and the histories of suicide prevention cen-

ters show that continued availability and publicity bring substantially greater use.

2. To set the goal of a change in the community suicide rate is neither logically nor materially sensible, particularly in the early stages of operation, and it can cause undue discouragement among the staff. Other means of evaluation are clearly preferable.

3. If the number or percentage of subsequent suicides among clinic users is to be an indicator of effectiveness in reaching suicidal persons, nothing less than a thorough follow-up study of all death records should be used. The substantial underestimation resulting from casual knowledge of completed suicides among callers promoted, in Chicago, the inference that the center was not reaching suicidal people.

4. Great care in selecting the means to evaluate suicide potential among patients and continuous monitoring of their effectiveness thru research is necessary. Grossly incorrect notions of suicide potential can be obtained by intuition or with indicators which are ill-adapted to the population to be evaluated.

5. Cases which call for emergency intervention seem to increase during the life of the center. If this datum is to be considered an index of the nature of the clients, it must also be interpreted with reference to the specific policy directives in the center concerning intervention.

6. Although there is an understandable temptation to feel that chronic callers are a nuisance and to exaggerate their use of the center, it appears that their number and use is low, their problems are more difficult to handle, and that they are more likely to eventually commit suicide.

Due largely to a confluence of circumstances and a lack of research, certain mistaken conclusions were drawn which adversely affected the operation of the Chicago Call For Help Clinic. It is hoped that this effort to set the record aright may be useful, not only for other organized efforts but also for those individual decisions which may help to prevent suicides. ◀

References

1. Bagley, Christopher, "The Evaluation of a Suicide Prevention Scheme by an Ecological Method," *Social Science and Medicine*, March, 1968.

(Continued on page 300)

Congress Undermining Confidence In Doctors, Medical Society Charges

Congressional announcements on physician payments under Medicare and Medicaid are part of a calculated plan to undermine public confidence in the medical profession, the Illinois State Medical Society charged in February.

Denouncing the recent Senate Finance Committee report on the subject as "distorted, evasive and full of innuendo," the ISMS Executive Committee said:

"It is obvious that certain aggressive forces in Congress—and some federal administrators—want to saddle the medical profession with all-out bureaucratic control."

The reference was to the Senate Finance Committee "disclosure" that 247 of Illinois' 15,000 licensed physicians collected at least \$25,000 from Medicare and Medicaid in 1968.

"What the reports do not indicate is that most of the physicians are working in the ghettos or other medically deprived areas and necessarily see hundreds of public-aid patients," said Dr. Frank J. Jirka, Chairman of the ISMS Executive Committee and Board of Trustees.

"Physicians have been criticized for moving from 'inner cities' to suburbs," Dr. Jirka continued. "Yet the government reproaches those who stay in the inner city and work long, devoted hours."

Washington creates the impression, he said, that doctors charge at will under Medicare/Medicaid. "Actually the payments adhere to the rates prevailing for the area and the services rendered. Besides, Medicare and Medicaid payments have been frozen since January, 1969."

While the Senate report criticized Medicare-Medicaid administration as well as physicians, Dr. Jirka commented:

"Stepped-up attacks on the doctor will prove easier than genuine internal reform. Physicians get only 11 cents of the Medicare/Medicaid dollar—considerably less than either the administrative cost or the hospital share. Yet we get an ever greater share of the abuse."

Instead of growing rich from government health programs, "doctors have suffered a marked loss in purchasing power since the 1950's because of inflation, taxes and sharp increases in overhead and malpractice insurance premiums," Dr. Jirka said.

The ISMS Executive Committee will communicate these views to the Illinois Congressional delegation and will make recommendations, said Dr. Jirka. "Organized medicine warned Congress that the Medicare/Medicaid programs, as proposed, would cost far more than the premium and taxes provided and would create patient overloads. However, Congress preferred to make the package deceptively attractive to the taxpayers."

"Now that the programs are accumulating deficits in the billions of dollars, certain elements in Congress want a whipping boy. The doctor suits the purpose because he's a familiar, identifiable figure—unlike the faceless bureaucracy and the hospitals whose charges in the 1960's climbed at double the rate of doctor bills."

Two contentions in the Senate Finance Committee report were that physicians "inflate" their Medicare/Medicaid incomes through itemized billing and "gang visits" to hospitals and nursing homes.

ISMS has advised physicians to deduct accordingly when visiting more than one patient in an institution, Dr. Jirka commented. Itemization, he said, is a result of Medicare/Medicaid rules and "a nuisance" to the physician. "In many such procedures the doctor is a victim not a culprit."

The Senate report called for "prompt action" by organized medicine to monitor care and charges under Medicare/Medicaid. Dr. Jirka said ISMS already has taken steps to set up a strong watchdog committee of physicians, in response to views expressed by the members in a written survey.

The Executive Committee also complained that Medicare administrators have "massively insulted the medical profession and its good judgment" through a notice which they send to patients who undergo treatments not covered by Medicare.

Instead of informing the patient that the procedure is not reimbursable under Medicare, the carrier tells him the procedure is "not medically necessary," thereby implying that the doctor is unethical.

After three years of protesting, Dr. Jirka said the Medicare carriers have finally agreed to change the letter . . . "but only after they succeeded in undermining public confidence in thousands of physicians."

Morbidity Patterns Reflected In A School During An

Human influenza is an acute communicable disease of the respiratory system. Its epidemic pattern predates the bacteriologic era. Influenza viruses exist in the forms known as A, B, and C. "A" strains were prevalent until 1943.¹ Since 1940, other "A" strains were identified and were designated A₁ since they differed from the classic "A" strains. In 1957, a new mutant appeared to originate from China and blazed a pandemic course engulfing most of the world. This strain was designated A₂ or Asian Influenza virus. Influenza A outbreaks occur every two to three years in North America and Europe.

BY DOMINGO DOMINIC JOSEPH LEONIDA, M.D.,
M.P.H./MORTON GROVE

Influenza is an infection spread by droplet from the respiratory tract. Virus is present in the naso-pharyngeal area from shortly before the onset of the illness until a day or two thereafter. Asymptomatic carriers disseminate infection. Recovery of the virus may be obtained from throat washings or swabbings.

The purpose of this work was to determine, in an expected influenza epidemic season, the morbidity pattern reflected through the school health program in schools where the immunization profile of students against the preventable contagious diseases are known to be above average.² Tabulations of certain absences from participating schools were gathered during this season.

Methods and Procedures

The children's immunization profiles against six preventable diseases (diphtheria, pertussis, tetanus, polio, measles and smallpox) were established through surveys in

the school health program. Monday, Wednesday, and Friday absences each week, associated with the symptoms of malaise, rhinorrhea, coryza, muscle-aches, or anorexia, were reported from each school. Reporting from three high schools and five elementary schools started in September, 1967, and ended in April, 1968. Rates were computed from the number of absences and total enrollment, and then plotted on graph paper. The baseline absentee rate ranged from 8% to 9%. The slopes traced by elementary and high school students were determined and contrasted with each other. Immunization status against influenza was not known in all students but was known among those who were absent due to illness. Thus, the morbidity experiences of elementary and high school students were compared during the season when the evidence of influenza or influenza-like disease would be high.

The average age among absentees in the elementary schools was 10 years and

Health Program

Influenza Epidemic Season

the range was between 6-13 years. The average age among the high school absentees was 16 years, while the range was between 14-18 years. The elementary school students in five schools numbered 2,314 while those in high school were 8,012.

Results

There is a rate of change among elementary school children from 11% absenteeism (254) at the beginning of the second week in November, 1967, to 21% (485) at the first week of December, 1967, (Fig. 1).

This represents an almost two-fold increase sustained over a three-week period due to flu-like illness. There were 10 attempts to culture the causative agent; only one specimen yielded Influenza A2 virus.

The rate of change in absenteeism among high school students went from 10% (801) during the last week of October to 33% (2,640) during the second week of November (Fig. 1). This indicates more than a three-fold rise in rate over a period of two weeks. The location of these schools do not favor a satisfactory geographical representation of the community.

Discussion

1. Density and dynamics

Individual resistance to a contagious disease varies from community to community depending upon many factors and the ease with which transmission is effected by population density. Dispersal of individuals in a population retards and impedes transmission of a contagious disease. Travel and flow of people from one place to another provides excellent opportunities for dissemination of contagious disease. In iso-

lated small towns and villages, with a small natural turnover in population, many common contagious diseases cannot maintain themselves over long periods of time. Dissemination potential is low in such a population. Schools with the larger enrollments experienced an accelerated transmission rate of the causative agent among students in contrast to smaller population groups. The peak in absenteeism is reached earlier during the season and deceleration in absentee rate is not so abrupt. The high school students averaged 2,670 per school in comparison to the elementary school students, who averaged 463 per school. The experience of the high school students illustrated the effect of density among susceptibles in the passage of influenza or influenza-like organisms.

2. Population susceptibility

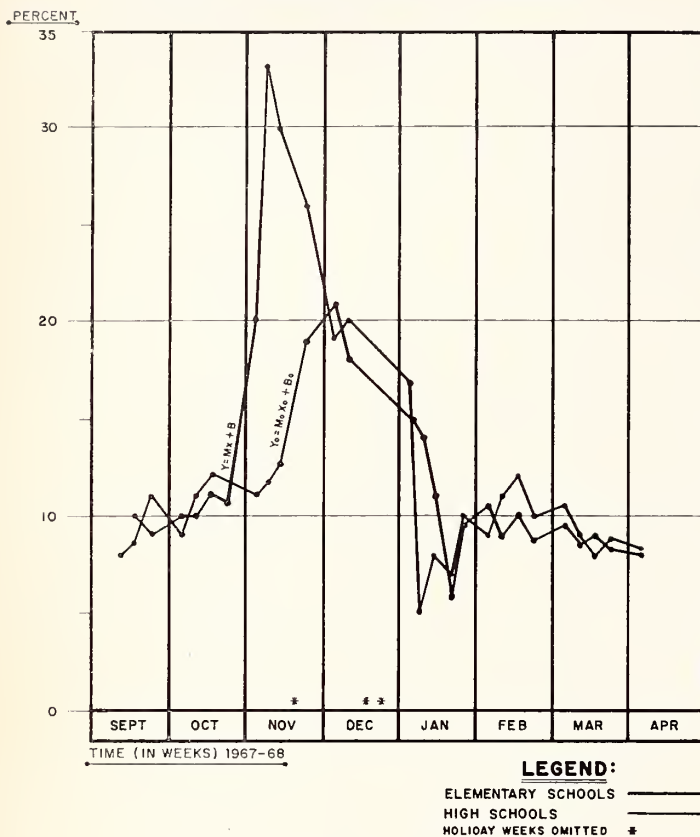
People vary in their genetic capacity to react and in previous experience with certain communicable diseases. The ratio of people at any one time which has little or no immunity determines the level of community or group susceptibility for a particular infectious disease. Since the immunity conferred is temporary (as in influenza) the same individual may be rein-



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SCHOOL HEALTH MORBIDITY EXPERIENCE DURING THE 1967-68 INFLUENZA SEASON SKOKIE, ILLINOIS

STUDENT ABSENTEEISM (In percent)



ected after a short interval. Thus, the disease attacks all ages: adults and old people as well as infants and children.

Reinfection is a distinct probability in the experience of both high school and elementary school populations. There were a total of 20,607 absences due to influenza-like illness a month before the peak of absences, during the peak, and a month after the lowest rate of absenteeism was reached. The ratio of high school absences in contrast to the elementary school absences was 4 to 1, which is the same ratio as the two populations.

Summary

A school health survey was made to map the morbidity pattern during the 1967-68 Influenza epidemic season among elementary school children (2,314) in five Skokie, Illinois, schools. The immunization profile against six preventable contagious diseases was well established through an earlier survey made in 1967. The density in student population ranged between 20 and 30 students per classroom.

The slope in absentee rate was determined for all five schools. Their individual slopes were found almost identical. Grouping was done to provide a group comparison with three adjacent high schools where enrollments ranged from 2,300 to 3,100. The elementary schools had enrollments ranging from 280 to 460. Student complaints for absences include combinations of the following: headache, nausea, vomiting, muscle-aches, fever, cough, rhinorrhea, malaise.

The smaller clusters of susceptibles in the elementary schools did not share the same transmission potential reflected by the high school students. The saturation of a larger susceptible population occurs more readily than in smaller clusters of susceptibles. The more gradual and lower peak reached by the elementary school pupils contrasted the abrupt slope that reached a peak higher and faster among the high school students. The steep slope in absentee rate experienced by the high school students might be a function of average age of susceptibles and/or population size per school.

The morbidity pattern etched by an epidemic "flu-like" illness among students participating in a suburban school health program is presented.

References

1. Van Rooyen, C. E., and Rhodes, A. J., *TEXT-BOOK OF VIROLOGY*, 1968.
2. Lipschultz, H. S., Duel, W., Diamond, S., "Community Immunity: How, When, and How Much?" *Illinois Medical Journal*, July, 1968.

The first NSMR booklet, *The Untouchable Heart*, appeared last year and received wide distribution and publicity through the American Heart Association, the American Medical Association, the National Association of Biology Teachers, NBC's *Guide to the Twenty-first Century*, and many other interested groups, schools and programs.

Unravelling the Mystery of Viruses is available from NSMR at ten cents a copy. Special prices are available for orders of large quantities.

Peer Review Guidelines

(See Lead on page 210)

County Medical Society Suggested Peer Review Guidelines

(To Be Modified As Needed)

I. PREAMBLE

Peer Review—the mirror that reflects every phase of medicine and “tells it like it is”—is a mandate already well established under Title 18 and 19 of the Social Security Act (Medicare and Medicaid).

Organized medicine desires to establish effective review mechanisms to aid in containing rising health care costs. The Blues have repeatedly said the usual and customary fee concept cannot survive without effective peer review. The question is not whether it should be done . . . but who will do it . . . the government or organized medicine? The following Guidelines represent the ISMS plan for peer review by County Medical Societies.

II. PURPOSE

The Peer Review Committee of a County Medical Society shall review all cases brought before it by physicians, patients, institutions, insurance carriers and government agencies. The committee should be concerned with the cost and quality of health care by the medical profession.

The committee should act as an intermediary between the involved parties in an attempt to resolve a dispute by arbitration. The committee represents the local county physicians in their desire to maintain a high quality of care and to aid in the control of the cost of medical care by keeping physicians' charges within the framework of the usual, customary and reasonable fees for a particular service in a respective geographic area; to keep utilization of services and facilities consistent with accepted standards of practice; and to protect physicians from unjust charges brought against them.

III. A POSITIVE APPROACH TO QUALITY CARE

The Peer Review mechanism should be considered as a positive approach to solving any inadequacies and/or irregularities in providing quality health care. It is a vehicle whereby quality medical care can be maintained within the framework of “usual, customary, and reasonable” fees for a particular service in a respective geographic area. It will keep utilization of services and facilities consistent with accepted standards of practice and at an acceptable cost in an inflationary economy.

IV. ORGANIZATION

The committee should be appointed by the President or Executive Committee of the local county medical society. It should be composed of a chairman and members who represent general practice and as many of the various specialties of medicine as possible. In

addition, the county peer review committee should have access to counsel from each of the various medical specialties as such consultation may be required.

The Peer Review Committee should include such sub-committees as the Grievance Committee, Prepayment Plans and Organizations, etc., as is appropriate for the particular county. Representatives of these sub-committees may also be members of the Peer Review Committee.

The County Medical Society's Ethical Relations Committee should continue as a separate unit primarily to:

- make disciplinary recommendations
- consider matters of ethical conduct and moral turpitude
- investigate prospective members

V. SCOPE OF PEER REVIEW

- A. To protect the public from any physician who may be incompetent, corrupt, dishonest, or unethical in his conduct.
- B. To protect the physician against ill-founded and unjust accusations of patients and/or such agencies who may be interested in securing, or financing health services.
- C. To accept complaints from all responsible sources.
- D. To review such records and other pertinent information which may be presented to it for the purpose of recommending appropriate action.
- E. To inform the public regarding the existence and functions of peer review committees.
- F. To adopt formal written procedures and policies, with appropriate records to process complaints and to notify complainants about disposition of their cases.

VI. REVIEW PROCEDURE

- A. Conditions Pre-requisite for Review by County Committee
 1. Evidence should be submitted to indicate an attempt was made to settle the dispute directly with the parties involved. Cases in litigation should not be considered.
 2. In fee disputes, the coverage involved must provide for payment of usual, customary and reasonable fees.
 3. A properly completed Peer Review Information Form must be submitted by the complainant to the Committee chairman together with all other appropriate documentation.
- B. Review Process
 1. Upon receiving a properly filed and documented case for review, the Chairman should promptly notify all interested parties that the case is

scheduled for hearing by the Committee at the next regular meeting. Such interested parties should be furnished with complete copies of materials used in the documentation of the case and, if appropriate, should be invited to attend the hearing.

2. In addition to hearing and taking action on cases filed by commercial carriers and fiscal intermediaries of medicare and medicaid, the Committee should also review cases from governmental agencies, and other medical institutions. The Committee should also review cases filed by a physician member against anyone of the above mentioned, and cases received from a patient against a physician. Again, notification to the interested parties should be provided and documentation should be required prior to the hearing.
3. The Committee should attempt to reach a decision on all cases brought to its attention. If the County Committee cannot reach a decision or does not desire to hear the case, it has the obligation of referring the case to the District Peer Review Committee. All interested parties should be promptly notified of decisions reached.

C. Reciprocal Responsibility

The operation of the Peer Review Committee as a review mechanism can be effective only if its decisions are honored by organizations and individuals who request the Committee's services. In the event of an appealed decision, the County Chairman should immediately submit the case to the State Peer Review Committee together with all appropriate documentation.

VII. DISCIPLINARY JURISDICTION

The County Medical Society's Peer Review Committee is not a disciplinary body. It does, however, have an obligation to report its findings and make recommendations to other appropriate county or district committees requesting the latter take action when warranted by the circumstances.

VIII. RESPONSIBILITY OF A COUNTY SOCIETY PEER REVIEW COMMITTEE

- A. The county medical society peer review committee should:
 1. Act as a "clearing house" for the county.
 2. Not interfere with established hospital and/or ECF peer review committees but work in close harmony.
 3. Offer assistance in establishing hospital and/or ECF peer review committees, if not already established and functioning.
- B. Composition of the committees:
 1. Members should represent as many of the various specialties as possible.
 2. Where possible, terms of service should be staggered to insure continuity.
- C. Availability:

The committee should accept complaints from all sources whether from the patient, physician, insurance carrier, or government agency.
- D. Public Information:

The committee should develop methods of regularly informing the public and physicians that there are peer review committees to resolve complaints on

fees, utilization of facilities and services, and to review the quality of medical care provided by the physician.

E. Priorities:

1. Peer review of unusually high fees and fee increases.
2. Over-utilization of services and fraudulent claims.
3. Utilization of facilities such as admission to hospitals, length of stay in hospitals (over which peer review committees would normally maintain surveillance) and length of stay in extended care facilities (ECF) and treatment objectives. The county peer review committee would work through the hospital committee when these items are the issues in referred cases.
4. Quality of hospital care is also a hospital function and the county committee would normally look to the hospital staff for assistance.
5. Ambulatory care is difficult to evaluate. However, a sincere attempt should be made to evaluate the quality of this care if it is questioned by outside agencies. It is better to have a peer mechanism investigating than a government agency visiting the doctor's office. If deficiencies exist, suggestions should be made to correct them.

F. Liaison with other agencies:

It is important to invite representatives of the agency referring the complaint to meet with the committee. This might be an individual insurance carrier, representative of HIC, HEW, or other government agency representative. The committee activity must be a sincere effort to bring about a just decision, otherwise we will be accused of a "whitewash." As soon as the peer review committee is functioning properly, the insurance carriers, Medicare fiscal intermediaries, government agencies, etc. should be requested to refer all questionable cases to the county society peer review committee.

G. Right of appeal mechanism:

It must be clearly stated that the peer review committee is a fact-finding mechanism, and recommendations are made on the basis of the facts. In the event of disagreement, the appeal mechanisms should be utilized. The peer review committee makes recommendations but does not act as judge and jury.

H. Records:

The committee should adopt formal written procedures and policies with special forms to record and process complaints and to notify the complainants about the disposition of their cases.

I. Liaison with hospitals:

Close cooperation with the chairmen of all hospital peer review committees is essential for smooth function and mutual assistance in handling referred cases.

J. Financing:

Financial assistance may be necessary for the smaller counties. The grouping of several smaller counties utilizing a centralized facility as a base would help reduce costs. (Additional study is necessary to establish cost estimates and to seek outside sources of funds to help defray the administrative expenses.)

Rx Products Index

Achromycin	208	Mucomyst	278-279
Achrostatin	301	Mead Johnson Laboratories	
Lederle Laboratories		Neo-Synephrine (Pediatric)	204
Ambar	282	Winthrop Laboratories	
A. H. Robins Company		Pro-Banthine	2nd Cover
Aventyl HCL	218-219	G. D. Searle & Co.	
Eli Lilly and Company		Phenaphen with Codeine	216
Dicarbosil	300	A. H. Robins Company	
Arch Laboratories		Quinamm/AVC	287, 288
Dimetapp	215	National Drug Co.	
A. H. Robins Company		Sinequan	273-276
Empirin Compound	222	Pfizer Laboratories Div.	
Burroughs Wellcome & Co.		Chas. Pfizer & Co.	
Equanil	226-227	StomAseptine	224
Wyeth Laboratories		Harccliffe Laboratories	
Indocin	268-270	Tetrex Bid Caps	223
Merck, Sharp & Dohme		Bristol Laboratories	
Ilosone	228	Tepanil	211
Eli Lilly and Company		National Drug Co.	
K-Lyte	206-207	Thera-Combex HP	203
Mead Johnson Laboratories		Parke Davis & Co.	
Librium	212-213	Urised	297, 298
Roche Laboratories		Conal Pharmaceuticals, Inc.	
Mylanta	3rd Cover	Vasodilan PVD	220-221
The Stuart Company		Mead Johnson Laboratories	
		Valium	Back Cover
		Roche Laboratories	



Membership Forum

Highway Tragedy

1969 was an ugly year for Americans. Tragedy of spectacular magnitude became a frequent front page occurrence. But a quieter national calamity took its dreadful toll on all the days before, during and after various offensives in Vietnam, riots, and assassinations.

It was "quiet" only because it was not concentrated in a single place at a single time. There was no focus to put this misery on the front pages. To the families and friends of

about 56,000 men, women and children killed in auto accidents, however, it was the ultimate calamity. To the millions of victims of injury, it was hard core agony. The economic loss, exceeding 13.5 billion dollars, was an appalling waste.

The 1969 highway toll followed a year that saw a leveling off in the number of highway deaths (55,300) and injuries (4,400,000). In 1967 approximately 53,000 lives were lost in motor vehicle mishaps—4,200,000 persons were injured.

Why the continued increase? Was it because Americans were lulled by the "improvement" of preceding years?

There are, perhaps, as many reasons as there are people to voice opinions.

Whatever the reasons, the tragedy remains.

Mr. Driver, it's up to you to help make 1970 beautiful!

Ed. note: Membership Forum is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.

ISMS To Revamp

Annual Meeting Format

In an attempt to provide wider interest in the Illinois State Medical Society's Annual Meeting, the 1970 Convention program has been changed significantly.

For the first time in several years, the Committee on Scientific Assembly, headed by Robert T. Fox, M.D., is planning several general sessions to be presented by a coalition of specialty groups. Tentatively scheduled are general sessions on medical education, drug abuse problems, coronary care units, and management of patients with respiratory insufficiency.

These half-day general sessions are designed to appeal to general practitioners, many specialists, interns and residents, medical students and, in some cases, nurses and technicians.

Traditional scientific sections have been

abolished, but all specialty societies have been invited to participate in one of the general sessions or to present their own programs. Those setting up their own programs have been advised to make the content of general interest rather than along strictly specialized lines.

The following specialty societies will have their own programs—Illinois Surgical Society, Illinois Society of Obstetricians and Gynecologists, Chicago Society of Allergy, Illinois Chapter of American College of Radiology, Illinois Academy of Pediatrics, and Chicago Dermatological Society.

The Convention will open Sunday, May 17, at the Sherman House with a meeting of the 1970 House of Delegates at 3 p.m.; other sessions of the House will be on Tuesday afternoon and Wednesday.

Official Call for Scientific Exhibits 1970 Annual Meeting of ISMS Chicago - - May 18, 19, 20

The Committee on Scientific Assembly invites members of the Illinois State Medical Society to submit applications for scientific exhibits at the Society's 1970 annual meeting, May 18-20 at the Sherman House Chicago.

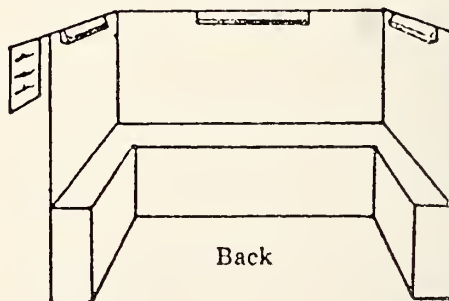
To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space at the meeting are requested to file an application before March 31, 1970, giving the basic equipment which will be needed. Awards are given exhibits of exceptional value. *Assignments are made after exhibits have been approved by the Committee on Scientific Assembly.*

There is no fee charged for scientific exhibits, but the exhibitor must pay the cost of installing the exhibit, of tables and chairs that may be rented, for alteration in shelves, equipment or construction. Single exhibit space is 8 x 10 feet.

Those interested in providing an exhibit are requested to file an application and a

full description of the exhibit. **DEADLINE FOR APPLICATIONS: March 31, 1970.**

CONTACT: Dr. J. Robert Thompson
Director of Exhibits
Illinois State Medical Society
360 North Michigan Ave.
Chicago, Illinois 60601



Single Exhibit Size—8 x 10 ft.

Cairo Physician Denies Charges of Lack of Medical Services

Charges by a black community organization in Cairo, Illinois, that the hospital and physicians there discriminate against blacks have been emphatically denied by Dr. Lewis S. Ent, president of the Alexander County Medical Society.

The problem began several months ago when members of the United Front, a small group of black militants in Cairo, charged that a young black woman injured in an accident was denied admittance to St. Mary's Hospital in Cairo because she did not have \$200.

Branding the charges a "fabrication," Dr. Ent said the story nevertheless appeared in news media in the Cairo and Chicago areas.

Dr. Ent said an investigation of the charges revealed the woman was admitted for observation at a Cape Girardeau, Mo. hospital, but signed herself out of the hospital.

Returning to Cairo, she contacted her personal physician, who is black. He said she refused to come in for an office examination. Without a doctor's orders, she could not be admitted to the hospital. She was driven to a Decatur hospital where it was determined her wounds were superficial, Dr. Ent said.

Her physician, Dr. A. L. Robinson, Mounds, maintains an office in Cairo. Dr. Robinson is president of the medical staff at St. Mary's Hospital and president of the medical society in nearby Pulaski County.

A second physician she contacted was Dr. Homer Chambliss, also black. He advised her to go to Dr. Robinson's office for an examination.

"It is ridiculous that any hospital in which two of the medical staff officers are black physicians could be termed "dis-

criminatory," Dr. Ent said. "It is equally ridiculous to charge that these two physicians would deny care to their own, or that any physician in Cairo would deny care to anyone, for that matter."

"Up to 80 percent of our practices involve public aid patients," he said. "The young woman involved in the original charges was on public aid," he said.

Sister Joan Marie, the hospital administrator, said that since 1964 the Sisters of the Holy Cross have willingly sustained more than \$500,000 in operating losses, over half attributable to free services to those unable to pay. The hospital has an emergency room which operates 24 hours a day, she said.

Dr. Ent and Sister Joan Marie said all public aid and medicare records, as well as medical staff minutes pertinent to the charges have been made available for inspection.

A "Flying Medics" group recently set up a one-day clinic in Cairo and said there was a need for additional medical care. Dr. Ent said there is a need for more doctors, and delivery of health care in outlying rural areas is a problem. But the same problems exist in almost any county in the United States, he said.

"You could go into the neighborhoods of the doctors who flew down here and also find people in need of medical treatment," Dr. Ent said. "It's not a matter of willingness to provide care, but of convincing all those who need care to see a doctor!"

Attempts to meet with the United Front to discuss complaints and possible solutions, including possible additional medical help or facilities, have been unsuccessful, he said.

Recommendations Made for Cook County Hospital Blood Bank

Ten recommendations covering administrative, professional and technical areas for the improvement of the Cook County Blood Banks were recently released by a special task force committee of the Chicago Medical Society. The report was submitted by a committee of ten citizens serving voluntarily and appointed by Dr. Fred A. Tworoger, President, Chicago Medical Society.

The report was the result of visits to the Cook County Hospital, to other blood banks, and interviews with members of

the community. Dr. James B. Hartney, Director of Laboratories, St. Anne's Hospital, served as chairman of the committee.

"A particular effort was made," he said, "to elicit derogatory information which might provide leads to significant avenues of investigation leading to areas in which improvement in services appeared necessary to the community."

In preparing its report, the committee was continuously mindful of its responsibility to the Medical profession, the staff and patients of Cook County Hospital.

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to help your
patients open
mucus-clogged
airways



new 10% solution...
particularly convenient for home use

MUCOMYST-10[®]

(ACETYLCYSTEINE)

**liquefies thick, viscid mucus
in chronic bronchitis and emphysema**

Mucomyst, as 20% acetylcysteine, has been used with safety and effectiveness in hospitals for over five years.

Now a new 10% solution, Mucomyst-10, offers you the choice of prescribing a lesser concentration whenever you feel this is desirable. It provides added convenience and simplicity, particularly for your patients using nebulizing units at home.

By including Mucomyst-10 in the home management regimen, you can provide full mucolytic benefits for many of your patients with chronic bronchitis and emphysema complicated by tenacious secretions.

Indications: Mucomyst has been demonstrated to be clinically effective as adjuvant therapy in a wide range of conditions in which thick, viscous mucus is a problem, including: postoperative atelectasis and pneumonia; chronic bronchopulmonary disease (emphysema, chronic bronchitis, asthma, and bronchiectasis); acute bronchopulmonary disease (pneumonia, bronchitis, and tracheobronchitis); tracheostomy care; facilitation of bronchial studies; maintenance of an open airway during anesthesia; and to help control pulmonary complications of cystic fibrosis. **Contraindications:** Mucomyst is contraindicated in those patients who are sensitive or who have developed a sensitivity to it. **Warnings:** After proper administration of acetylcysteine, an increased volume of liquefied bronchial secretions may occur. When cough is inadequate, the open airway must be maintained by mechanical suction if necessary. When there is a large mechanical block due to foreign body or local accumulation, the airway should be cleared by endotracheal aspiration, with or without bronchoscopy. Asthmatics under treatment with Mucomyst should be watched care-

fully. If bronchospasm progresses, this medication should be immediately discontinued. **Adverse Effects:** Adverse effects have included stomatitis, nausea and rhinorrhea. Sensitivity and sensitization to Mucomyst have been reported very rarely. A few susceptible patients, particularly asthmatics (see **Warnings**), may experience varying degrees of bronchospasm associated with the administration of nebulized acetylcysteine. Most patients with bronchospasm are quickly relieved by the use of a bronchodilator given by nebulization. **Administration & Dosage:** Mucomyst may be administered by nebulization into a tent, Croupette, face mask, or mouthpiece; or by direct instillation. **Mucomyst should not be placed directly into the chamber of a heated (hot-pot) nebulizer.** Complete details on dosage, administration, and compatibility are included in the package insert. Additional information may be obtained from Mead Johnson Laboratories. **Supplied:** Mucomyst-10 (acetylcysteine), a sterile 10% solution, in vials of 10 ml. and 30 ml.; Mucomyst (acetylcysteine), a sterile 20% solution, in vials of 10 ml. and 30 ml.

Mead Johnson
LABORATORIES

Clinics for Crippled Children Scheduled

Twenty-six clinics for Illinois' physically handicapped children have been scheduled for April by the University of Illinois, Division of Services for Crippled Children. The Division will count 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social, and nursing service. There will be five special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Apr. 1—Hinsdale—Hinsdale Sanitarium
- Apr. 1—Rock Island Cerebral Palsy—3808 Eighth Avenue
- Apr. 2—Flora—Clay County Hospital
- Apr. 2—Lake County Cardiac—Victory Memorial Hospital
- Apr. 2—Springfield General—St. John's Hospital
- Apr. 7—East St. Louis—Christian Welfare Hospital
- Apr. 7—Quincy—St. Mary's Hospital
- Apr. 8—Champaign—Urbana—McKinley Hospital
- Apr. 8—Metropolis—Massac Memorial Hospital
- Apr. 9—Cairo—Public Health Department
- Apr. 10—Chicago Heights Cardiac—St. James Hospital
- Apr. 14—Peoria—St. Francis Children's Hospital
- Apr. 15—Chicago Heights General—St. James Hospital
- Apr. 15—Mt. Vernon—Good Samaritan Hospital

- Apr. 16—Rockford — Rockford Memorial Hospital
- Apr. 16—Bloomington—St. Joseph's Hospital
- Apr. 16—Elmhurst Cardiac—Memorial Hospital of DuPage County
- Apr. 21—Rock Island Area General—Moline Public Hospital
- Apr. 22—Centralia—St. Mary's Hospital
- Apr. 22—Aurora—Copley Memorial Hospital
- Apr. 22—Springfield Pediatric Neurology—Diocesan Center
- Apr. 24—Chicago Heights Cardiac—St. James Hospital
- Apr. 24—Evanston—St. Francis Hospital
- Apr. 27—Peoria Cardiac—St. Francis Children's Hospital
- Apr. 28—Peoria—St. Francis Children's Hospital

Apr. 28—Belleville—St. Elizabeth's Hospital
 The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions, or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

ISMS Receives Grant

The Scientific Speakers Bureau of the ISMS Educational and Scientific Foundation received a grant of \$5,000 to continue the work of the Bureau. Presentation was made at the January Board of Trustees meeting in Chicago. The grant is from the Merck, Sharp and Dohme Pharmaceutical Company and has been presented for several years. This makes possible the many presentations at county medical society meetings. These are usually of a clinical

nature and do much in the way of continuing education. Regional Director for MSD, Mr. Joseph Head, was present for the awarding of the grant.

Gratitude to MSD is expressed for this interest in continuing medical education. County medical societies wishing to avail themselves of this service are urged to contact the Speakers Bureau in the Headquarters office.

Meeting Memos

March 20-21—Chicago Medical School

2nd Annual Conference on Brief Psychotherapy
"Confrontation Problem Solving Technique"
Kling Auditorium, Chicago

March 23-25—American Hospital Association

Institute on Disaster Planning
American Hospital Association, Chicago

April 1-2—The Cleveland Clinic Education Foundation

Postgraduate Course
"Advances in Infectious Disease"
2020 East 93rd St., Cleveland, Ohio

April 3-4—American Geriatric Society

27th Annual Meeting
Americana Hotel, New York

April 6-7—The Cleveland Clinic Education Foundation

Postgraduate Course
"Sports Medicine"
2020 East 93rd St., Cleveland, Ohio

April 6-17—University of Illinois

Postgraduate Course in Laryngology and Bronchoesophagology
Eye and Ear Infirmary, University of Illinois, Chicago

April 9-10—American Medical Association

23rd National Conference on Rural Health
Pfister Hotel and Tower, Milwaukee, Wisc.

April 12-18—The American College of Obstetricians and Gynecologists

18th Annual Clinical Meeting
Americana Hotel, New York

April 16-18—Mound Park Hospital Foundation, Inc.

Postgraduate Course
"The Pulse of Laboratory Medicine"
St. Petersburg, Fla.

April 17-18—University of Kentucky

Program
"How to Use Mechanical Ventilators Effectively"
Albert B. Chandler Medical Center, University of Kentucky, Lexington, Ky.

April 21—Chicago Pediatric Society

Resident's Meeting and Dinner
Presbyterian-St. Luke's Hospital, Chicago

April 22-23—The Cleveland Clinic Education Foundation

Postgraduate Course
"Postgraduate Course in Pathology"
2020 East 93rd St., Cleveland, Ohio

April 23-24—National Tay-Sachs Association

Symposium
"Lipid Storage Diseases"
University of Illinois, Illini Union, Chicago

May 17-20—ISMS Annual Meeting

Sherman House, Chicago

August 20-22—University of Wisconsin

9th National Conference on Therapies for Advanced Cancers
University of Wisconsin, Post-Graduate Center, Madison, Wisc.

Possible Adverse Relations to Drugs

A second fact that every physician must consider is that the more drugs that any one individual gets at any one time, the greater is his possibility of developing an adverse effect. For example, if two drugs are given, the incidence is 4.7 per cent, whereas if twenty drugs are given, a 45 per cent incidence of adverse effects is likely to occur. This is significant when we consider that the average hospitalized patient receives approximately seven during his stay, sometimes this many at one time. We should make an effort to keep our therapies as limited and as restricted as possible and avoid a whole variety of drugs acting at the same time unless there is absolutely sound reasons for such, and the physician and patient are willing to take the risk of difficulties developing. (Dale G. Friend, M.D.: "Useless Drugs, Preparations and the Prescription Fallacies of Physicians." *J. Maine Med. Assoc.* 60:11 [Nov.] 1969.)

The
AMBAR®
SCRAPBOOK
of

Obesity Oddities

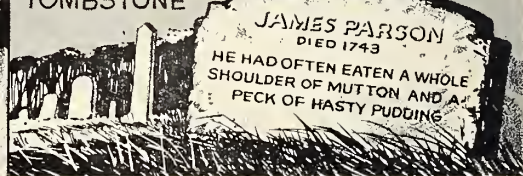
FACT & LEGEND

OBESITY WAS A MILITARY OFFENSE!

OVERWEIGHT ROMAN HORSEMEN WERE MADE TO FORFEIT THEIR MOUNTS AND BECOME FOOT SOLDIERS!



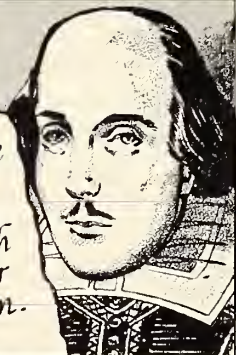
RECORDED ON AN ENGLISHMAN'S
TOMBSTONE



SHAKESPEARE

WAS AWARE OF THE
DANGERS OF OBESITY
HE WROTE...

*Make less thy body hence
and more thy grace;
leave gormandizing;
know thy grave doth
gape for thee wider
than for other men.*



THE
COST OF
**AMBAR
EXTENTABS**

IS APPROXIMATELY ONE
HALF THAT OF OTHER LEAD-
ING APPETITE SUPPRESSANTS

AN IMPORTANT FACTOR
IN LONG TERM THERAPY



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

methamphetamine HCl 15 mg.,
phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

BRIEF SUMMARY/Indications: Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A-H-ROBINS

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

BY JOSEPH J. LOTHARIUS

Unveil Guidelines for County Peer Review

Peer Review Guidelines to evaluate the cost and quality of medical care and help curb wasteful practices in medicine were unveiled at the 1970 ISMS Leadership Conference in February. (Complete guidelines are published in this issue). Nearly 300 physicians from all parts of the state heard Dr. Frank J. Jirka, Jr., ISMS Board Chairman, urge local county societies to implement local peer review as quickly as possible "because the health and welfare of our patients are at stake." Dr. Jirka said the primary objectives of peer review are to conserve the patient's health care dollar; to assure the appropriate use of health care personnel facilities; and to maintain the high standards of medical practice. He emphasized that peer review was "a two-way street" that enabled MDs to state their grievances and, in turn permit patients, governmental agencies, and third party carriers to be heard.

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Medicare Eligibility No Job For MDs

Physicians should only be concerned with evaluating and treating a Medicare patient's medical needs. They should not be burdened with having to determine the patient's eligibility for extended care, according to a statement endorsed by the ISMS Board of Trustees. The statement, prepared by the Committee on Aging, requests Medicare to clarify its regulations on certification for extended care patients. Specifically, MDs have been certifying patients on the basis of their *medical* judgment and assuming that the patient is technically eligible for Medicare benefits when in fact some patients are not.

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MD's Asked To Prescribe P.T.

Widespread misunderstanding of physical treatment services reimbursable under Medicare and other third party carriers prompted the ISMS Board of Trustees to approve guidelines to help MDs better prescribe and evaluate physical treatment services. The Committee on Rehabilitation Services, which prepared the guidelines, believed these were necessary after being notified by Medicare and several third party insurers that MDs are giving physical therapists too much discretion in ordering and delivering physical therapy services. Physical therapists thus have been placed in a position of practicing medicine which in some cases has led to abuses of Medicare and other insurance benefits.

Object To Blue Cross Interpretation

ISMS Board of Trustees voiced their objection to a Blue Cross interpretation of a Social Security Administration directive on physical therapy services covered by Medicare. The Society's Aging Committee, in requesting Board action on the matter, said the Blue Cross interpretation requires that a patient receiving restorative therapy should be mentally capable of responding to the therapist's instructions. This interpretation amounts to discrimination against the patient on the basis of his diagnosis, the Committee reported. "If the patient derives benefit from the treatment, his mental status is irrelevant," the committee said.

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IDPA Reviews Billing Codes

IDPA announced that charges by individual MDs have been reassessed on the basis of the past two years of operation, in accordance with an agreement between IDPA and ISMS. Starting immediately, IDPA will process bills for many procedure codes throughout the state at a re-evaluation of the updated prevailing community rates. Previous rates were based on fees in effect in 1966. This revision is primarily an updating of the "cost of doing business."

IDPA cautioned this should not be considered as an indication that the new determination of prevailing rates will result in increased payments to every MD for every procedure code. The revisions will primarily affect some 30 counties and relate to the most common procedure codes including routine office and hospital visits. Prevailing rates are still governed by directions from HEW.

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Medicaid Pay Higher In Illinois Than Kansas or Texas

Illinois' MDs treating Medicaid patients are more fortunate, dollar-wise, than their colleagues in either Kansas or Texas. According to a recent report published in the American Hospital Association's *Hospital Week*, Kansas has cut Medicaid payments to doctors. The Kansas State Department of Social Welfare (Kansas Medicaid administrator) has initiated a policy of paying 75 per cent of bills submitted by MDs, dentists, and optometrists for services to Medicaid beneficiaries.

A check with Robert G. Wessel, chief of the Division of Medical Administration for IDPA (Illinois administrator for Medicaid), revealed the statewide ratio of payments to charges in Illinois averages 90 per cent. As for Texas . . . a recent story in *Wall Street Journal* reported the Texas Public Welfare Commission voted to cut Medicaid benefits by 20 per cent effective April 1 because of "rapidly escalating costs." That state's deputy welfare commissioner said further cuts may become necessary.

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Medicare-Medicaid Payments Over \$600 Reported to IRS

Medicare Part B Carriers and Medicaid administrators are required by IRS to report payments to a physician totaling more than \$600 per year. After Jan. 1, 1971, all commercial carriers will be required to report payments of \$600 or more in one year to a MD.



Better Patient Care !!

BY MISS PHYLLIS VOGT/DUPAGE COUNTY

In a recent article of *Medical Economics*, January 20, 1969, p. 146, Dr. W. L. Howland discussed "Now my office nurse holds office hours, too." He went on to state that he was attempting to improve the efficiency of his office and at the same time maintain a better level of patient care.

His assistant has her own schedule of appointments—approximately 20 a week—during the hours when the doctor is in the office. Her duties include checking blood pressures of hypertensive patients, instructing diabetics in diet and weight control and teaching patients physical therapy procedures to be carried out in the home. The average appointment is for a 15 minute period with the nurse and "usually requires less than 30 seconds of the doctor's time."

According to Dr. Howland, "nurse appointments have made it possible for me to serve more patients and, I believe, to serve them more effectively."

Well, doctor, that is basically the aim of the Medical Assistants Association—to serve you and your patients more efficiently and to maintain a higher level of quality care. With our continued educational programs, both at regular monthly meetings and in special education classes organized in many local chapters, we are able to keep abreast of the changes in medical care, increase our efficiency in assisting the doctor in examinations and improve our procedures of book-keeping, billing, and those endless insurance claim forms. If the assistant is confi-

dent in what she is doing this sense of confidence is quickly transmitted to the patient who is, in turn, more relaxed and mentally prepared to cooperate and be more receptive to your care and treatment—**BETTER PATIENT CARE!** This is such a basic rule, but one which we often forget in the turmoils of modern day medical practice. Our organization is constantly reminding us of these "general rules" as well as the latest ideas which apply to specialized medicine. As you, Doctor, become more specialized, so should your staff of assistants.

We, of the Illinois Medical Assistants Association, are so enthusiastic and confident of this continual change that we are sponsoring a medical assistant in a scholarship program on the national, state, and sometimes even on the county level—for we are constantly striving to encourage young people to join this wondrous world of medicine and its many related fields. We are *sold* on our product—service to the patients—and are proud to sell it whenever and as often as we can. So encourage your medical staff to become involved with the local organization of the Medical Assistants Association—we know they will enjoy our product—**BETTER PATIENT CARE!**

For more information, please contact either Mrs. Vivian Johnson, First Vice-President, 9105 S. Albany, Evergreen Park, Illinois 60642 or Mrs. Mary Siers, Second Vice-President, 801 North 84th Street, East St. Louis, Illinois 62203.

Who Says It's Unhealthy?

"Consumerism is no unhealthy thing. It is a compliment, even if perhaps a backhanded one, to the genius of the American business system. Having given the people so much it is human that the people should expect more."—Jenkin Lloyd Jones, president, Chamber of Commerce of the United States.

NEW PHARMACEUTICAL SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

The following new drugs have been marketed:

NEW SINGLE CHEMICAL

HMS Corticoids-Local R

Manufacturer: Allergan

Nonproprietary Name: Medrysone (USAN)

Indications: Allergic and vernal conjunctivitis, episcleritis and epinephrine sensitivity.

Contraindications: Acute untreated purulent ocular infections, acute herpes simplex keratitis, viral diseases of the conjunctiva and cornea, ocular tuberculosis, fungal diseases of the eye and hypersensitivity to any of the components.

Dosage: One drop in conjunctival sac up to every 4 hrs.

Supplied: Plastic dropper bottles—5 cc. sterile suspension.

DUPLICATE SINGLE PRODUCTS

CEVI-BID Vitamins—Geriatric o-t-c

Manufacturer: Geriatric Pharmaceutical Corp.

Nonproprietary Name: Ascorbic Acid

Indications: Vitamin C deficiency.

Contraindications: None known.

Dosage: One capsule daily, or as directed by physician.

Supplied: Sustained-release capsules—500 mg.

PAVACEN Antispasmodics. R

Manufacturer: Central Pharmacal

Nonproprietary Name: Papaverine Hydrochloride

Indications: Cerebral and peripheral ischemia associated with arterial spasm and myocardial ischemia complicated by arrhythmias.

Contraindications: Use with caution in patients with glaucoma.

Dosage: Usual dose: 1 every 12 hrs.

Supplied: Capsules—150 mg.

RUBELOGEN Biological R

Manufacturer: Parke, Davis

Nonproprietary Name: Rubella virus vaccine, live.

Indications: Immunization against German measles.

Contraindications: Do not administer to pregnant women. Sensitivity to dihydrostreptomycin, polymixin B, dogs or dog dander. Febrile illness, leukemia, lymphoma, generalized malignancy or lowered resistance due to therapy with corticosteroids, alkylating drugs, antineoplastic agents or radiation. Separate vaccination at least one month from administration of other live virus vaccines, blood transfusion or immune globulin.

Dosage: Injection, i.m. or s.c.—0.5 cc.

Supplied: Vials

TRANTOIN Antiinfectives—Urinary R

Manufacturer: McKesson

Nonproprietary Name: Nitrofurantoin

Indications: Pyelonephritis, pyelitis and cystitis.

Contraindications: Anuria, oliguria or significant impairment of renal function. Pregnant patients at term and infants under three months.

Dosage: Children: 5-7 mg/kg/24 hrs, in equal doses q.i.d. Adults: 50-100 mg. q.i.d.

Supplied: Tablets—50 and 100 mg.

COMBINATION PRODUCTS

CETA-TAR Shampoo Coal tar, Sulfur &

Resorcinol Preparations o-t-c

Manufacturer: Alcon

Composition: Salicylic Acid 2.0%

Benzalkonium Chloride 0.2%

Coal tar mixture of polyoxyethylene ethers.

13.0%

Alcohol

Indications: Control of seborrhea.

Contraindications: None mentioned.

Dosage: Shampoo twice weekly.

Supplied: 4 fluid oz. bottles.

CONTRABLEM Coal Tar, Sulfur &

Resorcinol Preparation o-t-c

Manufacturer: Texas Pharmacal

Composition: Colloidal sulfur 5.0%

Resorcinol 2.0%

Alcohol 9.5%

Indications: Acne.

Dosage: Apply thin film on affected area twice daily.

Supplied: Tube.

HISTASPAN-PLUS Cold Preparations—

Antihistamines R

Manufacturer: USV Pharm.

Composition: Chlorpheniramine maleate 8.0 mg.

Phenylephrine HCl 20.0 mg.

Indications: Upper respiratory tract infections.

Contraindications: Hypersensitivity to any component of the drug.

Dosage: Adults and children over 12: 1 capsule every 12 hrs.

Supplied: Capsules, sustained release.

CALADRYL Spray Antipruritics—Local o-t-c

Manufacturer: Parke, Davis

Composition: Calamine

Diphenhydramine 1%

Camphor

Indications: Antihistaminic and antipruritic.

Contraindications: None mentioned.

Dosage: Apply to affected area.

Supplied: Pressurized containers—2 and 4 oz.

It's Time to Wake Up!

"In committing ourselves to the future we must take the disruptions we find in our life today, not as signs of decay, or of death of the American dream, but as prods to awaken us to do, out of necessity, what we have neglected for too long to do out of choice."—Arch N. Booth, executive vice president, Chamber of Commerce of the United States.

Looking for a Place to Practice?

Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

Subsequent to the listings over the past 24 months, the following list of openings for associates in general practice is furnished. These pertain to downstate. Previous listings related to Cook County. This will be continued next month.

ADAMS COUNTY: Quincy; population: 46,000. Openings in Physicians and Surgeons Clinic, 1101 Maine Street, Quincy for general practitioner, dermatologist, internist, ophthalmologist, otolaryngologist, pediatrician, urologist, orthopedist, general surgeon, vascular-thoracic sub., and industrial medicine. Group of 20 established in 1945. Opportunity for partnership after 2 years. Four story brick building. Sixty-five additional physicians in county. One private swim club with indoor and outdoor pools. Two 18 hole country clubs, plus 27 hole municipal layout. Forty-eight manufacturing plants and 30 processing plants. Excellent school system, plus Quincy College. Minimum salary: \$22 to \$24,000 negotiable. For details contact: V. E. Stillman, Business Mgr. Physicians and Surgeons Clinic, Quincy. Phone: 222-6880.

CUMBERLAND COUNTY: Toledo; population: 1,000. Rhodes Clinic needs GP to replace partner leaving to specialize. All expenses paid, 3 man clinic serving large area; 2 weeks vacation, nights, 7 weekends rotated; opportunity to join partnership in 6-18 months. Nearest hospitals at Mattoon & Charleston. Sources of income: agriculture & industry. Four Protestant churches.

Grade & high schools. Contact: L. E. Masie, M.D., Toledo. Phone: 849-8151.

DEKALB COUNTY: DeKalb; population: 28,000. Trade area: 40,000. Forty-six physicians in county including 30 GPs. Only 19 in clinical practice in DeKalb. Three hospitals in county with 250 beds. Available space in well equipped medical building. Lab, X-ray facilities and pharmacy in building. Agriculture and industry. Twenty churches. Grade and high schools. Northern Illinois University located here. Substantial guarantee offered to establish practice. Contact: James C. Ellis, M.D., DeKalb Medical Center. Phone: 815-758-3495.

DUPAGE COUNTY: Downers Grove; population: 21,500. Opening for a GP in new medical center. Population increasing. Thirty physicians at present. Twenty miles from Chicago and Aurora. Eight prescription drug stores. Nineteen churches. Grade and high schools. Recreational facilities include seven golf courses and two swimming pools. Contact: Norman Young, M.D., 4333 Main Street, Downers Grove. Phone: WO 9-7700.

EDGAR COUNTY: Paris; population: 13,000. Trade area: 60,000. Immediate opening in Medical Center Clinic. Established in 1958. Seven physicians in group, including 3 GPs, internist, surgeons and radiologist. Salary 1st year \$16 to \$19,000. Opportunity for partnership after year. New air-conditioned building with lab, EKG, X-ray and library next door to hospital. Twelve physicians in community including 9 GPs. Paris Hospital; 75 beds. New 120 bed hospital construction to start. Eighteen churches. Grade and high schools. Twenty-five miles to Eastern Illinois University and Indiana State University. Excellent golf course. For details contact: J. M. Ingalls, M.D. Phone: 5-0514 Paris.

FAYETTE COUNTY: Vandalia; population: 5,500. Opening with Moore Clinic; two GPs, need for a third. Ultra modern 103 bed hospital. New high school. Located on Kaskaskia River. Sixty miles from St. Louis, County seat of Fayette County. New clinic building, three blocks from hospital. Three consultation rooms, 10 examining rooms, office, receptionist, waiting room; large parking. For details contact: S. W. Moore, M.D. or D. H. Rames, M.D., Vandalia. Phone: 283-0945 or 283-1209.

Response of Staphylococcal Respiratory Infections To Dicloxacillin

BY LESTER A. NATHAN, M.D./SKOKIE

Dicloxacillin* (Fig. 1), a new semisynthetic penicillin produced by acylation of 6-aminopenicillanic acid with 3-(2, 6-dichlorophenyl)-5-methylisoxazol-4-carboxylic acid, is active against many gram-positive bacteria, including staphylococci both susceptible and resistant to penicillin G. Various experiments *in vitro*¹⁻⁵ and *in vivo*^{1,2,6,7} have demonstrated its acid stability,^{4,6} good absorption after ingestion,^{3,5,7} and activity against streptococci,¹ pneumococci,¹ and the penicillinase-producing staphylococcus.^{1,2,4,8} Animal and human pharmacological studies¹⁻⁸ have provided extensive data on its oral blood levels and oral LD₅₀ range, particularly in rodents and cats.⁶ Its rate of urinary excretion (67 to 76% in the first 24 hours)^{3,5,6,8} is slower than that of other semisynthetic penicillins,⁸ possibly because of extensive protein binding (92 to 97%).^{2,3,5,6,8,9}

*Pathocil® (Sodium Dicloxacillin Monohydrate), Wyeth Laboratories.

Method and Material

This series consisted of 41 young patients who had infections by the coagulase-positive *Staphylococcus aureus* in pure culture. The 41 were selected by culture and Sensi-Disc® test from among 160 who, with a single exception, were suffering from pharyngitis, tonsillitis, bronchitis, or other respiratory infection. In the 119 excluded cases, the infection was caused by mixed or non-pathogenic microflora, viruses, or single bacteria other than coagulase-positive *S. aureus*.

The patients and the oral dicloxacillin treatment schedule are shown in Table I. The children were about equally divided as to sex (22 boys, 19 girls). Eighteen of them were adolescents (12 to 18 years of age). The higher dosage (1 Gm. per day) was employed more frequently in these older, heavier children. Nevertheless, 12 children weighing less than 90 pounds, all but five of whom were prepubertal, had infections severe enough to require the higher dosage. The period of treatment varied from 5 to 10 days, depending on the individual infection (mean treatment period, 8 days).

The patients had been ill from one to four days before seeking treatment. The

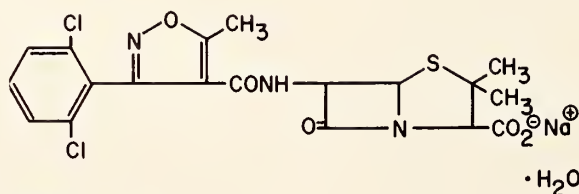


Fig. 1

Table I
Correlation of Age/Weight with Dicloxacillin Dosage and Clinical Response

Weight	Age, yr.			No.	Dicloxacillin Dosage		Clinical Response		
					High*	Low†	Cured	Improved	Unimproved
lb.	4-7	8-11	12-18	Pts.	12	14	13	11	2
30-89	7	14	5	26					
90-159		2	13	15	14	1	4	11	
Totals	7	16	18	41	26	15	17	22	2

†125 mg. orally four times a day for 5 to 9 days (mean, 8).
*250 mg. orally four times a day for 6 to 10 days (mean, 8).

clinical diagnoses are shown in Table II; pharyngitis, bronchitis, and tonsillitis predominated. All except three strains of *S. aureus* proved sensitive to dicloxacillin.

Adjunctive therapy consisted of aspirin (10 patients), cough syrups (5 patients), and nose drops (1 patient). One patient, a 12-year-old boy who had lymphangitis and septicemia, received intramuscular penicillin G, and another patient, a 10-year-old boy who had pneumonitis and asthma, needed adjunctive antispasmodics and bronchodilators.

Results

The response is shown in the two tables. At the time medication was discontinued, 17 patients (41%) were clinically cured (i.e., had become completely normal), 22 (54%) were improved (i.e., fever had subsided and other symptoms had nearly disappeared), and 2 patients (5%) had failed to respond. One of the latter had pharyngitis and the other had tonsillitis and cervical adenitis. Both of these infections were due to dicloxacillin-resistant strains of *S. aureus*. When the organisms still persisted after one week of treatment, dicloxacillin was discontinued. One patient was then treated with ampicillin and the other with chloramphenicol. Both responded slowly. A third patient, an 8-year-old girl, also harbored a dicloxacillin-resistant strain of *S. aureus*, but her bronchitis responded and she appeared clinically cured at the end of the first week of treatment at the lower dosage level despite the persistence of the organism in culture. All other *S.*

aureus strains, in all the patients, were eliminated by the treatment.

In general, as shown by laboratory studies, treatment resulted in hematologic normalization. In one child with cervical adenitis, a 1+ urinary albumin found at initial examination cleared up during treatment.

Side effects occurred in six patients but were too mild to require any special therapy or even the discontinuation of dicloxacillin. Five had looseness of the stool, and three of these also had abdominal cramps or discomfort. One patient had a mild urticaria on the fifth day, but the treatment was continued four more days without further adverse effects.

Comment

In practice, dicloxacillin is employed primarily as a penicillinase-resistant antistaphylococcal penicillin. Although its effectiveness in this use has been extensively documented, the studies seldom have been confined exclusively to coagulase-positive *S. aureus* infections of the upper respiratory tract in children, and it was felt that this specific pediatric application should be investigated.

The data obtained in the present series suggest that orally administered dicloxacillin is a safe and relatively effective treatment for such infections.

Summary

Forty-one young patients, mainly children less than 12, all of whom had infections (mostly respiratory) by the coagulase-positive *Staphylococcus aureus* in pure culture, were treated orally with 500 mg. or 1 Gm. dicloxacillin daily in courses ranging from 5 to 10 days. The total dosage per course averaged 6 Gm. As shown by disc sensitivity tests, three specimens of the organism were resistant to the drug. These cultures were still positive at the end of one week of treatment, and two of the infections failed to respond clinically. All

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Table II
Diagnosis vs. Response to Treatment

Diagnosis	No. Pts.	Cured	Clinical Response		Response of <i>S. aureus</i>	
			Improved	Unimproved	Eliminated	Persisted
Pharyngitis*	21	9	11	1	20	1
Tonsillitis†	7	3	3	1	6	1
Bronchitis**	8	2	6		7	1
Sinusitis	1		1		1	
Otitis media‡	2	1	1		2	
Cervical adenitis	1	1			1	
Septicemia with lymphangitis	1	1			1	
Totals	41	17	22	2	38	3
Percentages		41	54	5	93	7

*Complicated by cervical adenitis (4 cases), tonsillitis (1 case), and impetigo (1 case).

†Complicated by cervical adenitis in 4 cases.

**Complicated by pharyngitis (3 cases), impetigo (1 case), and pneumonitis and asthma (1 case).

‡Complicated by pharyngitis and cervical adenitis in 1 case.

other infections were either cured (41%) or improved (54%); in other words, 95% of all patients treated responded satisfactorily. Five children had loose stools and one had mild urticaria. ◀

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Obituaries

***E. Stuart Braden**, Evanston, died in January at the age of 51. He was vice president and medical director of the Allstate Insurance Companies.

***David M. Cohen**, Chicago, died Jan. 30 at the age of 62. He was chairman and professor of the department of dermatology at the Chicago Medical School.

***Charles M. Hausman**, Chicago, died Jan. 24 aboard the U.S.S. Rotterdam while on vacation. He was 64 years of age.

***Hilger P. Jenkins**, Chicago Heights, died Jan. 17 at the age of 67. He was a pioneer in surgical and medical cinematography.

***Abe Matheson**, Chicago, died Jan. 21 at the age of 68. He was head of the pediatric and allergy departments of Michael Reese Hospital.

***Theodore H. Miller**, Chicago, died Jan. 10 at the age of 74. He was senior attending physician at St. Elizabeth's Hospital.

***George H. Pflueger**, Crystal Lake, died Jan. 20 at the age of 86. He was past president and past secretary of the McHenry County Medical Society and a member of the ISMS Fifty-Year Club.

***Arthur M. Pincson**, Chicago, died Jan. 10 at the age of 76. He had been a consultant to the Chicago Board of Health for 20 years.

George L. Samuels, Alton, died Jan. 14 at the age of 86. He was the first Negro doctor in Alton.

***John E. Stanton**, Chicago, died Jan. 22 at the age of 75. He was a member of the ISMS Fifty-Year Club.

*Indicates member of Illinois State Medical Society.

Expand Journalism Awards

Due to increased numbers of entries in the Annual ISMS Journalism Awards competition, the Board authorized the awarding of plaques to entries finishing second in the judging in each category. Plaques will be presented by the District Trustee through the local county medical society. This will provide closer relations between the news media and the local medical societies and will give recognition to many excellent journalists around the state. The project will be financed through the IMJ improvement fund, established under the ISMS Educational and Scientific Foundation to improve medical journalism.

Leadership Conference to Assist Illinois Physicians

The Board approved final plans for the Annual Leadership Conference to be held on February 8. The Conference will jointly explore the growing problem of Malpractice suits and procedures for establishing a statewide peer review system.

Peer Review

Peer Review Guidelines, proposed by the Council on Economics and Governmental Health Programs were adopted after in-depth study and debate by the Board. (Guidelines are published in the March IMJ) A proposed plan for combining existing Prepayment Plans and Organizations Committees and Grievance Committees into Peer Review Committees at the State, District and County Society levels, was referred to the Constitution and By-Laws Committee. The Committee will prepare the necessary changes for consideration by the 1970 House of Delegates.

Certification Against Fraud

The Board voted opposition to proposed medical regulations from the Department of Health, Education and Welfare, requiring physicians to sign a fraud disclaimer when billing the Public Aid Department. HEW will be advised that such a disclaimer is unnecessary and demeaning to physicians. IDPA also is in opposition to this move.

Coroner System Study Committee

A special Coroner Study Committee is attempting to develop suitable alternatives to the present coroner system. The Board went on record as favoring removal from the constitution all references to "coroner". This position is to be forwarded, through appropriate channels, to Con-Con. Removal of this requirement in the Constitution is necessary before changes can be made by the General Assembly. The ISMS Committee is attempting to coordinate the views of all medical and paramedical groups on this issue for a unified approach to Con-Con.

Specialty Society Representation on ISMS Councils

To improve communications and provide closer liaison, membership on the ISMS Councils was granted to specialty societies of medicine. Representatives to serve in this capacity may be nominated by the specialty society approved by the Board of Trus-

tees, and designated as consultants to the Council without vote, in compliance with the ByLaws.

Himler Report to be Studied

Revamped AMA policies and programs, as proposed in the report of the Committee on Planning and Development at the Denver meeting, were submitted to the Board. The complete report will be sent to the Trustees and all Councils and Committees, and an abridged version sent to all county medical societies with the request that the report be studied and opinions and suggested resolutions be sent to the ISMS AMA delegation for presentation to the next AMA House of Delegates. This detailed report's ramifications are far-reaching and Dr. William Ford, delegation chairman, called for good analysis to enable the delegation to present objective resolutions.

Location Plans of Medical Students to be Surveyed

A survey of medical students to determine their plans for locating in practice after graduation was authorized. This is to provide background information to help retain medical personnel in Illinois.

Professional Liability Concerns

Legal counsel reviewed, for the Board and the Executive Committee, numerous problems confronting physicians in Illinois with respect to malpractice suits. A request from the Southern Illinois Medical Association for ISMS to query the insurance carriers about reasons for denying or dropping coverage was favorably acted upon. A request from the Hospital Association to approve the requirement that physicians show proof of Malpractice Insurance coverage as a condition of staff appointment, was not endorsed. A progress report from the Medical-Legal Council indicated no action as yet from the Bar Association on the proposed formation of a Malpractice Screening Panel. An Ad Hoc Committee of the Board was appointed to explore further methods of meeting what appears to be, growing problems in the malpractice field.

Budgets for 1970 Approved

Detailed proposals for 1970 budgets were presented by the Finance Committee. For the Operating Fund, a balanced budget of \$902,025 was approved. This is an increase of less than 5% in operating costs in the face of an increase of 6.2% in the Bureau of Labor Statistics Consumer Price Index. The increase in expenditures will be met from existing sources of revenue with no increase in dues.

The Budget of the Benevolence Fund and the Foundation Financial Statement were also accepted.

Support for Rubella Immunization Campaign

At the request of the Child Health Committee, the Board acted in support of campaigns to ensure compliance with state immunization laws. ISMS will cooperate with medical societies and health departments in pressing for inoculation of all children. Federal funds may be available to the state to help in this endeavor.

Commission to Study Health Care Costs

The Commission to Study Health Care Costs, created by the passage of Senate Bill 1139 in the 76th General Assembly, is expected to report its findings in early April. By official action, a request will be made for representatives of ISMS to meet with the Commission prior to that time.

Surgeons May Not Include Cost of Assisting Surgeon

By a one-vote margin, a recommendation of the Usual & Customary Fees Committee to allow the surgeon to bill IDPA for the assisting surgeon's fee under certain conditions, was rejected. The rule would apply only when the assisting surgeon is not the referring physician. In acting in this fashion, the Board upheld present IDPA policy which requires each physician to render a separate billing.

Following an opinion by legal counsel that a doctor may assign his right of payment to someone else, the Board went on record as favoring a system whereby the physician could request governmental agencies and insurance companies to honor assignments of payments to others.

Refresher Courses to be Scheduled

At the request of the Council on Education and Manpower, the Board authorized the Committee on Scientific Assembly to schedule refresher courses for recognized post graduate credit at the annual meeting when sufficient enrollment can be assured.

Merck, Sharp & Dohme Grant Received

Mr. Joe Head, Regional Manager, Merck, Sharp and Dohme, presented a check for \$5,000 to the Education and Scientific Foundation to continue the work of the ISMS Scientific Speakers Bureau. This gift, which has been received annually for many years, provides honoraria and travel expense for speakers at county medical society meetings.

Physical Therapy Guidelines

Approval was given to a set of Guidelines to physicians when prescribing physical treatment, as developed by the Council on Social and Medical Services. The guidelines clarify the appropriate procedure to be followed in ordering physical therapy treatment and make the distinction between physical therapy and restorative nursing care. In related action, the Board supported the Council's objection to an interpretation of Medicare regulations by Blue Cross that restorative therapy requires that a patient be mentally capable of responding to the therapists instructions. The Council contends that if the patient derives benefit from the treatment, his mental status is irrelevant.

Director of Mental Health

By official action, the Board directed that a letter be sent to the Governor inquiring as to the status of appointment of a Director of Mental Health. The latest recommendations of the Governor's Search Committee were endorsed as suitable for the position.

In other actions, the Board—

- Voted to cooperate with the Medic-Alert program but refused formal endorsement;
- Authorized continued membership of ISMS in the Illinois Association of the Professions, under a revised council structure—individual sustaining memberships will be retained at \$10 per year;
- Approved a consent form developed by legal counsel, for making anatomical gifts for transplants, etc.—the form to be distributed to physicians and hospitals;
- Scheduled the July 18-19 Board meetings in the Chicago suburbs, and the October 24-25 meetings in Belleville;
- Moved to strike from the ByLaws the term "annually" as it pertains to review of the Society's committee structure by the Committee on Committees. The Committee will henceforth make a review when directed by the Board of Trustees;
- Expressed support of the AMA position opposing the legalization of marijuana and recommended that the House of Delegates be asked to consider this matter;
- Approved a request to recommend to the deans of Illinois medical schools, inclusion of sex education courses in the curriculum;
- Accepted in principle the concept that uniform pregnancy leaves should be granted state employees, i.e., six weeks pre- and post-partum with an additional 4-6 weeks without prejudice at either end upon certification by the patient's physician;
- Approved of an IDPA pilot program to determine feasibility of paying specialists usual, customary and reasonable fees for a predetermined period of time to induce them to render more care in medically deprived areas;
- Authorized appointment of an ad hoc committee of the Council on Medical Education and Manpower to meet informally with osteopathic physicians to explore ways to eliminate barriers to practice and providing more health care in Illinois.

Appointments and authorizations—

- Dr. John Rathe, Moline, was appointed to the Committee on Continuing Education, replacing Dr. Bertelsen who was forced to withdraw due to illness;
- Appointed Dr. Bertram Moss, Chicago, as the ISMS representative to the ad hoc committee of Hospital Planning Council of Metropolitan Chicago;
- Approved nomination for appointment to the new Illinois Department of Public Health ad hoc Emergency Health Study Committee Drs. William Hark, James Kurtz, Colman O'Neill, Max Klinghoffer;
- Endorsed for appointment to the Illinois Department of Registration and Education Committee on Licensure of Physical Therapists, Drs. A. Rodriguez, Chicago, Hugh McMennamin, Peoria, Ali Khalili, Chicago and Albert Siegel, Springfield;
- Recommended the appointment of Dr. Irving Abrams, Chicago, as consultant to the Commission on Children;
- Recommended the appointment of Dr. Frank Jirka, Jr., to the Advisory Committee to the IDPA.

ISMS ANNUAL CONVENTION, MAY 17-20, CHICAGO

On National Health Insurance

Only last month the AMA's House of Delegates renewed its support of solo practice (sometimes called "pushcart medicine in an age of supermarkets"), fee for service, choice of physician and other traditional mainstays of American medicine. It passed over the advice of a report which declared that:

"Until and unless the association addresses itself publicly, actively and objectively to the resolution of the very concrete problems that exist in health care, its attempts to justify present delivery systems and payment mechanisms will be incomprehensible both to the public and government and will be interpreted as self-seeking on the part of the profession."

In its own way, however, the AMA is responding to increasing demands for change. For example, for the first time in more than 50 years the AMA is advocating a national health insurance plan.

The plan, called Medcredit, is far tamer than Walter Reuther's proposal for a universal health insurance, but it shows that the AMA is trying to stay in the race.

Every responsible medical leader in the land admits with varying degrees of reluctance that a national health insurance plan is inevitable.

All but the most conservative leaders concede that the United States will have such a plan in effect within five years. Some of the proponents confidently predict a shorter time. Most everybody agrees it will be an important issue in the 1972 presidential election. ("The Shape of Medicine in the 1970s." Reprinted from the "Los Angeles Times," Sunday, Jan. 11, 1970.)

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BASIC GYNECOLOGY, One Week, April 27
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BASIC INTERNAL MEDICINE, One Week, April 6
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Suicide Prevention

(Continued from page 260)

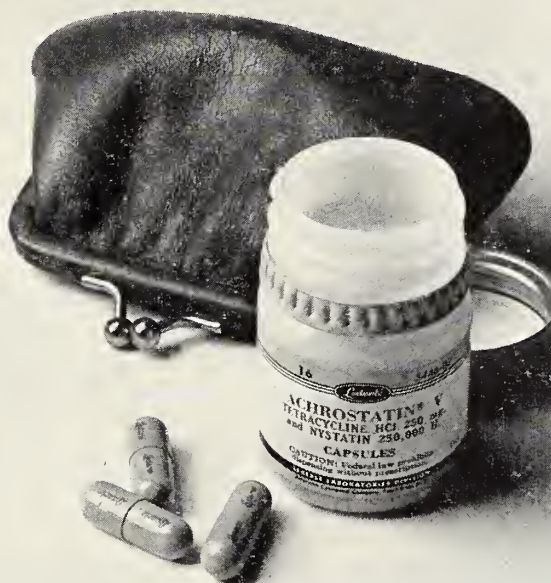
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THE VIEW BOX

(Continued from page 238)

DIAGNOSIS: Traumatic A-V fistula, Fig. 3.

The patient had an audible bruit. The fistula permits rapid passage of blood from the artery to the vein on the basis of a pressure gradient; the resulting increase venous return raises a cardiac output proportional to the left or right shunt while pulse pressure increases and tachycardia develops. In an extremity A-V fistula, an increase in the size of the involved extremity may be associated with a palpable thrill and an audible bruit. As chronicity occurs varicosities of the involved side will be noted. The radiographic findings in long-standing A-V fistula with sufficient shunt calcification may be seen as demonstrated in Figures 1 and 2. On arteriography the premature opacification of a corresponding vein during the arterial phase is pathognomonic of A-V fistula. The feeding artery is usually enlarged in character with multiple collaterals. The simultaneously visualized venous structure may be dilated due to incompetence of the valve and presence of contrast material distally in the vein. Reversal of flow may occur in the distal artery and vein if the A-V fistula is large enough. Vascular steal patterns may be demonstrated if there is a significant amount of shunting.

Reference

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A film that points the way to better treatment for the mentally ill is now being offered by the U.S. Department of Health, Education and Welfare as a public health service. Suggested for community groups and organizations, high school or university students or TV showing, the film entitled, "A Community Mental Health Center—The New Way," is available in 16mm. color from National Medical Audiovisual Center, Station K, Atlanta, Georgia 30324.

Many innovations as well as continuation of the best features of past clinical sessions are planned for the Annual ISMS Convention, May 17-20, Sherman House, Chicago.

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CONVENTION • Delegates Handbook	367
• Resolutions	430
• Program Summary	432
• Exhibits	439

CLINICAL ARTICLES

Morphological Effects of Intrauterine Contraceptive Devices <i>Ralph M. Wynn, M.D.</i>	333
Report on Fatality: Fluid Extract of Ipecac, Spider Bite <i>Norman J. Rose, M.D., M.P.H.</i>	338
Prolapsus Uteri with Pelvic Kidney <i>Vincent S. DiGiulio, M.D.</i>	344
Gastric Obstruction from Gastrostomy Tube <i>Richard M. Vazquez, M.D., Marshall Goldin, M.D., and Steven Economou, M.D.</i>	357
Fractures of the Hand <i>Irwin M. Siegel, M.D.</i>	360

SURGICAL GRAND ROUNDS

Epiphrenic Diverticulum of the Esophagus	347
--	-----

SPECIAL ARTICLE

Guidelines for Prescribing Physical Therapy	355
---	-----

FEATURES

The President's Page	320
The View Box	340
Editorials	342
The Doctor's Library	346
Clinics for Crippled Children	351
Obituaries	352
Membership Forum	353
Meeting Memos	354
Physicians Placement Service	356
New Pharmaceutical Specialties	366
Illinois Medical Assistants Association	451
Socio-Economic News	457

(Cover story on page 317)

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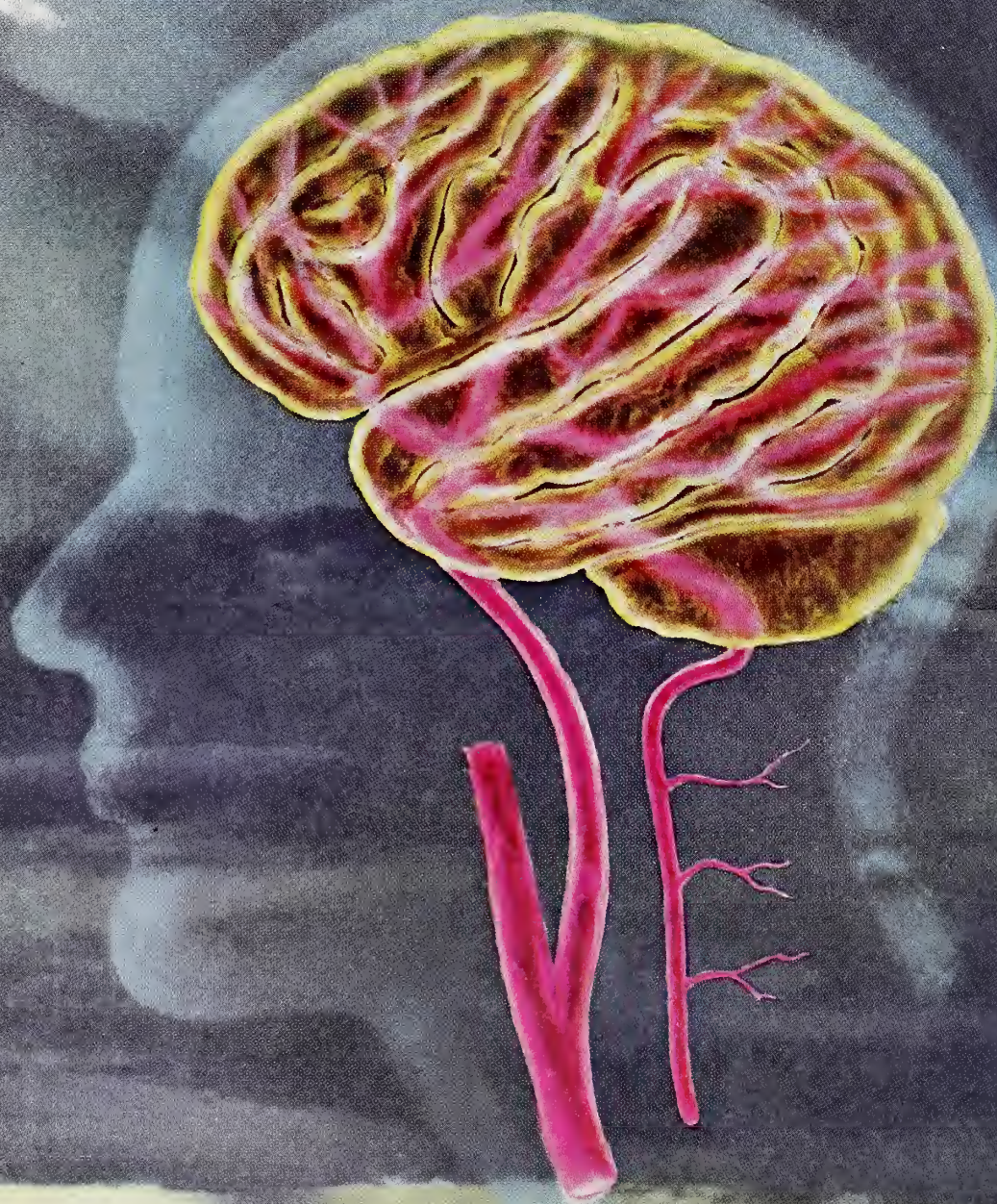
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Vol. 4, No. 4

April, 1970

Medical Care Price Index

At present, the best yardstick available to measure relative changes in medical care prices over a period is the Medical Care Price Index, a component of the Consumer Price Index. Obtained by survey and prepared by the Bureau of Labor Statistics, the Index, containing numerous items, undertakes to represent all medical goods and services customarily purchased by urban wage earners and clerical workers.

Among the items included in the index are physicians' fees with several subdivisions such as office visits, home visits; obstetrical care; appendectomy and tonsillectomy; dentists fees, hospital services, health insurance, optometric examinations and eye glasses, drugs and pharmaceuticals are also included among the items in the Index.

The Consumer Price Index, sometimes erroneously referred to as the "cost of living index," is composed of about 400 items, each of which is weighted according to its relative importance. Weights are based upon the percentage of city wage earners' and clerical workers' annual budget that is spent on a specific quantity of various goods and services. The medical care portion of the Consumer Price Index accounts for 5.7% of the entire index with housing and food weighted the highest at 33.23% and 22.43% respectively.

All major groups of the Consumer Price Index have shown large increases in price over the past three decades. Nevertheless, attention has been focused on medical care prices, even though they play a minor role in the entire Index relative to other major groups. For example, it would require an increase of 17.5% in the Medical Care Price Index to raise the Consumer Price Index 1%. In contrast, a rise of 1% in the Index would result from an advance of only 3% in the housing component.

The Consumer Price Index and its components is probably the most used and often misused single government statistic. Users of statistics can often distort results to parallel conclusions to support a desired position. When referring to the rising medical prices based on data available from the Index, several points must be considered:

(1) The Index is based on a population of urban

wage earners and clerical workers and may reasonably apply only to this population and not to other age and occupational groups.

(2) The Index is made up of specific categories such as "Physicians' fees" and "Dentists' fees," and more inclusive categories such as "total health care" and "Medical Care Services."

Medical care services, as it is called by the Bureau of Labor Statistics, contains chiropractors' fees, physicians' fees, examinations, prescriptions, and dispensing of eye glasses, hospital service charge, laboratory fees and health insurance overhead costs which will not give an accurate description of the trend in physicians' fees. Yet, frequent reference is made in popular journals as well as scientific journals about the rising cost of doctors' bills based on categorical price changes of "medical" care services included in the overall Index.

Furthermore value judgements are often assessed to price levels on the basis of trends reported in the CPI and include such statements as, "hospital care prices are too high" and that "prices are shooting right off the statistician's graph," even though such value judgements are not meaningful in terms of measurable objectivity.

Furthermore, price indexes fail to make due allowance for quality changes. This fact is probably more serious in the medical care price index than in other components of the CPI. For example, when looking at price changes in hospital rates, there is, thus far, no way of taking into consideration changes in the entire cost of services received. Although the price per day for hospital rates which the Medical Care Index measures has been going up, the average hospital stay as well as of the hospital stay for particular diseases has been decreasing.

Much publicity has been given the increase in the cost of medical care services that must necessarily be placed in perspective through a consideration of their significance relative to other items the consumer commonly purchases. Because of the relatively low weight of 5.7% for the total health care component an increase in price would have considerably less effect on expenditures of urban wage earners and clerical workers than a comparable increase in the food and housing component.

(This is not an advertisement)

Additional Services to Professionals

Two representatives have been added to the professional relations staff to provide services to physicians and their office assistants in the central and southern part of Illinois.

Mr. John Meisner's area includes the Illinois State Medical Society's Trustee Districts 6, 7, 9, 10 and Sangamon and Montgomery counties. He can be contacted at Illinois Blue Shield's District Office, 525 West Jefferson Street, Suite 100, Springfield, Illinois 62702.

Mr. Gerald Wilton's area includes the Medical Society's Trustee Districts 2, 4, 8 and 5 except for Sangamon and Montgomery counties. Mr. Wilton can be contacted at Blue Shield's District office, 1201 North Street, Peoria, Illinois 61604.

ASK BLUE SHIELD

• • • ABOUT MEDICARE Independent Laboratories

The Social Security Administration classifies an independent laboratory as one which is not physician directed. Before Medicare payments can be allowed, the independent laboratory must be certified by the Illinois Department of Health according to standards developed by the Department of Health, Education and Welfare. Services covered by Medicare, when performed in an independent laboratory at the request of a physician, include pathological tests, microbiological, serological, chemical, hemotological, biophysical, cytological, and immunohemotological tests when performed in connection with a definite diagnosis or set of symptoms.

In order to keep physicians in the counties of Cook, Kane, Will, Lake and DuPage informed we will publish regularly in the Blue Shield Report for Illinois Physicians, the names of the laboratories which have been newly certified as well as those which are no longer certified.

Newly Certified Laboratories

1. 1101 Clinical Laboratory, 1101 Howard Street, Chicago, Illinois.
2. Division Medical Lab., Inc., 2625 West Division Street, Chicago, Illinois.
3. Professional Arts Medical Laboratory, 601 West Central Road, Mount Prospect, Illinois.
4. Aurora Clinical Laboratory, 143 South Lincoln Ave., Aurora, Illinois.

No Longer Certified

1. Plaza Laboratory, 101 South Washington Street, Park Ridge, Illinois.

2. Clinical Laboratory, 143 South Lincoln Street, Aurora, Illinois.

When you do utilize the services of an independent laboratory, and charges for the services are included in your bill, please indicate the name of the laboratory. Medicare regulations state that the medicare beneficiary can not be charged more than the amount charged by the laboratory for the services.

How to Request A Medical Review

Illinois Blue Shield as Part B Medicare Carrier in the five county area of Cook, Kane, Will, Lake and DuPage, has been informed by the Social Security Administration that all requests by physicians or beneficiaries to have a Medicare claim reviewed must be in writing. This may be done by letter to the Part B Medicare Carrier or by completing SSA Form 1964 which may be obtained from the Medicare office or from all Social Security offices.

When requesting a review, please include additional information which you feel will be an aid in reviewing the claim. Also please include the case number and the date which appears in the upper right corner in the Explanation of Benefits form as they will help us in returning the results to you promptly.

Itemization of Office Visits

When you complete a SSA 1490, Request for Payment form, or provide your patient with an itemized statement and your charges include office or hospital visits, please indicate whether the charge for the initial visit is more than for subsequent visits. Also indicate unusual circumstances necessitating more than usual care in your office or in the hospital. This information will aid us in making payments to you or to your patient accurately and promptly.

Our Government Contracts Division

reports that Federal Health Insurance benefits under Title XVIII, Part B of P.L. 89-97 were paid during February for over 52,300 cases in the counties of Cook, DuPage, Kane, Lake and Will for an amount exceeding \$2,904,100. For the year 1970 through February, payments have been made on over 119,500 cases for over \$7,003,600.

The number of cases processed in February under Part A exceeded 69,000 with payments to providers amounting to more than \$25,500,000. For the year 1970 through February over 132,000 cases have been processed and payments to providers have exceeded \$54,400,000.

VALUE OF ONE VOTE

How important is one vote? If you think of its importance in terms of something contributory to the overall good of your city, state and nation—fine and dandy. But the foremost consideration must be its importance to you.

Your vote is your voice in the government of your country. As a shareholder in the biggest free corporation in the world, you declare with your vote your rights and privileges as an American citizen. And as an American citizen, you are casting your vote to continue every one of those freedoms for which so many people you never knew have given their blood, sweat, tears and lives to preserve for you. How important is one vote?

Well—in 1645, one vote gave Oliver Cromwell control of England.

In 1649, one vote caused Charles I of England to be executed.

In 1776, one vote gave America the English language instead of German.

In 1839, one vote elected Marcus Morton Governor of Massachusetts.

In 1845, one vote brought Texas into the Union.

In 1868, one vote saved President Andrew Johnson from impeachment.

In 1876, one vote changed France from a Monarchy to a Republic.

In 1876, one vote gave Rutherford B. Hayes the Presidency of the United States.

In 1923, one vote gave Adolph Hitler leadership of the Nazi Party.

In 1941, one vote saved Selective Service—just 12 weeks before Pearl Harbor!

And in 1960, a difference of less than one vote in each precinct of the U. S. elected John F. Kennedy president.

How important is one vote? Your vote? A wise man once said, "Liberty means responsibility—this is why most men dread it."

Do you dread it? Or do you consider liberty your responsibility—to be preserved where it counts most; in the ballot box? Is one vote all that important? **You bet your free life it is!**

ON THE COVER ISMS CONVENTION FORMAT DISCLOSED

The format for the ISMS Convention, May 17-20 at the Sherman House in Chicago, places an emphasis on general sessions of broad interest rather than the many section meetings that have been featured at past conventions.

A general interest session will be conducted each day of the convention: Monday's session will be on "Medical Education and Its Relation to Community Health Needs;" Tuesday will feature "Drug Abuse Problems;" and Wednesday there will be an all-day program on coronary care with the morning portion designed for physicians and the afternoon session for technicians and nurses.

In addition, the Illinois Surgical Society, the Illinois Obstetrical and Gynecological Society, the Chicago Society of Allergists and Allergy Foundation of America, the Illinois Chapter of American College of Radiology, the Academy of Pediatrics, and the Illinois Chapter, College of Chest Physicians will present general interest programs as well as programs appealing primarily to their own members.

The opening session of the 1970 House of Delegates will be at 3 p.m., Sunday, May 17, followed by Reference Committee meetings that evening and further sessions of the House on Tuesday and Wednesday.

Scientific meetings will begin Monday morning with operative clinics at Cook County Hospital and an obstetrical gynecological program at the hotel. A noted speaker is scheduled to speak at the Public Affairs Dinner Monday night.

On Tuesday there will be a diabetes symposium conducted by the U.S.V.P. Company, an all-day allergy program, the afternoon portion of which will feature case presentations, and a continuing education program in psychiatry sponsored by the Chicago Medical School, with the annual ISMS President's Banquet in the evening.

Wednesday, in addition to the general sessions on coronary care, there will be a pediatric and a dermatology program as well as a seminar on "Management of Patients with Respiratory Insufficiency."

Special programs on aging, and an medicine and religion are also on the agenda.

The Convention program handbook begins on page 367.

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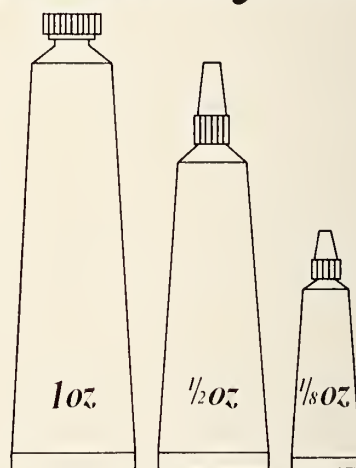
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Edward W. Cannady, M.D.

The President's Page

What's Peer Review All About?

Why all the fuss about peer review?

Can peer review prevent further government controls over our profession?

The answers to these questions are so vital to our professional future that I would again like to discuss the subject in depth.

Peer review is:

- OUR way of watching and safeguarding the quality, quantity and cost of the medical care we give;

- OUR way, in that it's conducted at the state and local level, with fellow physicians acting as the review bodies;

- OUR way of confronting the people on the other side of the health-care aisle—the insurance companies, the Medicare intermediaries, the government agencies, the hospitals;

- OUR way of showing the public that we're in earnest . . . that most physicians observe the usual and customary fees and the highest precepts . . . and that infractions can be adjusted BY US.

A peer review committee is not a police court. It cannot subpoena you to answer a complaint against you. It cannot penalize or discipline you. But you should cooperate with it . . . and honor the ultimate decision.

Peer review can be as far-reaching as we care to make it. Let's use it as a means of education and enlightenment for all of us, and for the medical-care world. Peer review is not simply removing the "bad apples" from the doctor barrel. Even the finest apples can have a spot or two. Honorable physicians can overcharge, overuse, over-prescribe—because of fixed ideas or excessive caution, or confusion over government requirements. Peer review would call these things to our attention.

In our 1969 Membership Survey on Ma-

jor Issues, you demonstrated your belief in peer review. You endorsed it for suspected "bad apples" in our profession . . . for physicians suspected of incompetence due to age or sickness.

Now let's move from "yes" on the survey to a concerted "yes" in action.

As physicians, we should feel at home with peer review. It's as old, in principle, as the advice given by Hippocrates to his colleagues. It's ingrained in the way examining boards and specialty boards give licensures and diplomas. A doctor's use of consulting specialists, or of pathologists and radiologists, is peer review. Further impetus for peer review came with Medicare and the growth of prepayment plans.

We're now ready for the final touches. Your state Society is consolidating its peer review mechanism into one committee that will serve as an appellate body for the entire state. It will consist of representatives from the various medical specialties and will have access to additional consultation from specialists when necessary.

The ISMS Council on Economics and Peer Review, as it will be called, include the functions of the existing Prepayment Plans and Organizations Committee and the Committee on Usual and Customary Fees. It will act on appeal cases presented to it by county peer review committees, individual physicians, commercial health carriers, fiscal intermediaries of Medicare and Medicaid, governmental agencies, hospitals and other medical institutions.

The Council on Economics and Peer Review will also serve as a "watch-dog" over all third party carriers, including government health programs, and call administrative abuses to the attention of physicians and the public.

(Continued on page 464)

Morphological Effects of Intrauterine Contraceptive Devices

By RALPH M. WYNN, M.D./CHICAGO

Although intrauterine devices (IUD's) are an effective form of contraception, neither they nor any other currently available methods fulfill the criteria of a perfect method of population control. The obvious advantages of the IUD include the small expense, the ease of initial distribution and follow-up, the absence of need for recurrent motivation, and the lack of direct temporal association with coitus. Additional advantages of the modern inert stainless steel and polyethylene devices include freedom from many of the complications of Gräfenberg's original silver ring.⁷ Acceptability of the IUD depends upon its effectiveness and safety and, indirectly, on its method of action. Effectiveness implies proof of a low pregnancy rate, and safety requires absence of immediate and long-term effects. The interpretation of mode of action involves semantics, and perhaps even theology, in ascertaining whether these devices cause abortion, interfere with fertilization, or act through other means.

With IUD's the actual effectiveness (use-effectiveness) is almost as great as the theoretical effectiveness, or the maximal effectiveness when the method is used perfectly, since there is no requirement for daily medication or contraceptive manipulation related to intercourse. Their theoretical maximal effectiveness is not so high as that of the best oral compounds, in either combined or sequential form, but their actual effectiveness, particularly in an educationally deprived population, is much greater than that of conventional methods.

The IUD's have been shown to affect some phase of the reproductive process in all animals tested,^{4,19} although their mode of action varies greatly among different species. Uterine effects may be mediated through chronic uterine stretch, disturbance of the synchrony of ovular and endometrial development, or alteration in decidualization. In several species, the endometrial effects appear to reflect a change in sensitivity to ovarian steroids. Although no serious pathologic changes have been found in studies in human or subhuman primates, subtle effects on endometrial maturation have been disclosed. The relevant

Presented, by invitation, at the meeting of the Illinois Obstetrical and Gynecological Society, Chicago, Illinois, May 19, 1969. Supported in part by Research Grant M.68.71 from the Population Council.

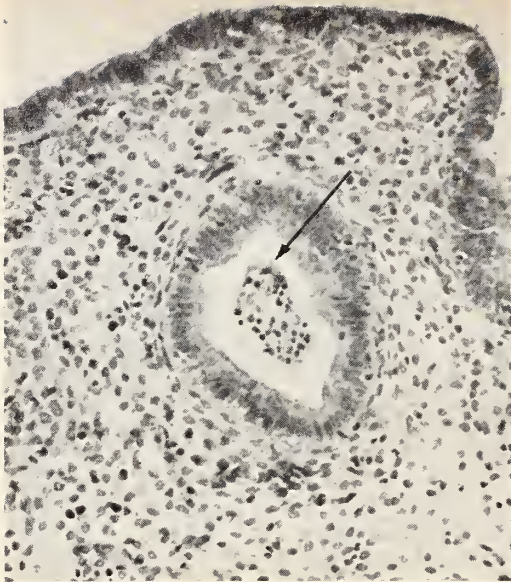


Fig. 1. Early secretory endometrium with pus (arrow) in glandular lumen. IUD in place 18 weeks.

histologic observations have been inconsistent, however. The ultrastructural confirmation, furthermore, is yet to be provided by more extensive studies in several laboratories.

Histological effects. The only constant histological alteration described in the literature is mild, transient, local inflammation, which clears after several weeks.^{2,3,6,9,10,14,15,18} Polymorphonuclear leukocytes are almost always found adjacent to the IUD. Plasma cells, lymphocytes, edema, and distended vessels are commonly found locally, in addition. Immediately beneath the device, the effects of direct compression of the endometrium are obvious, and stromal fibrosis is occasionally observed. No study of human cervical or endometrial mucosa by biopsy or exfoliative cytology, however, has revealed any anaplasia, to say nothing of carcinoma, causally related to the IUD.

Histological studies of changes in endometrial maturation have been inconclusive. Some investigators report no change in the cyclic histological pattern. Others refer to a retardation in the secretory phase. Tamada and co-workers,¹⁷ for example, describe a delay in maturation of the portion of the endometrium in contact with the IUD; they mention, furthermore, a slight suggestion of squamous metaplasia, which has not been confirmed by others. More significantly, perhaps, they describe a generalized predecidual response at mid-

cycle, a change that could interfere with successful ovoidimplantation. No consistent histochemical changes have been reported, except possibly an increase in the intensity of the Alcian blue reaction suggesting greater depolymerization of mucopolysaccharides.⁵

In our own histologic studies, neither proliferative nor secretory endometria showed any consistent generalized pathologic change. Specimens of endometrium distant from the loop could usually be dated histologically, according to the criteria of Noyes, Hertig, and Rock,¹¹ on the basis of the glandular pattern. Six weeks after insertion of the IUD, telangiectasis and infiltration of polymorphonuclear leukocytes were usually found. For longer periods of time, however, endometritis persisted near the loop, often with pus in the lumina of the glands (Fig. 1). A more general change, even in areas distant from the loop, affected the stromal cells, which appeared precociously developed. A predecidual pattern with periarteriolar cuffing was often found by the midsecretory stage and occasionally as early as just after ovulation. The stroma immediately beneath the loop, however, appeared compressed and fibrotic throughout the cycle (Fig. 2).

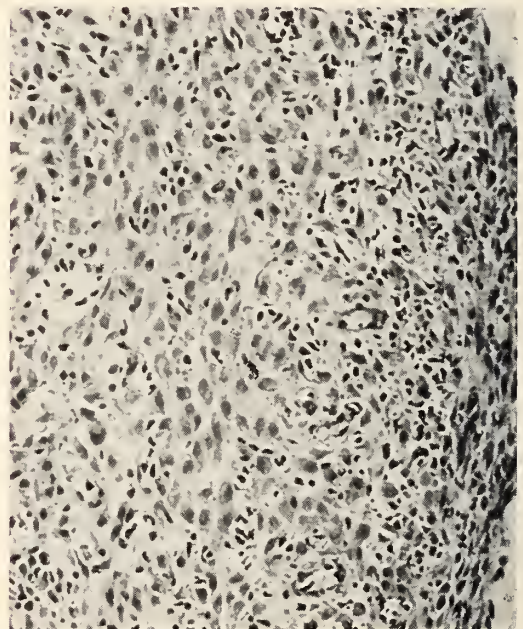


Fig. 2. Endometrium immediately beneath loop, showing compression and apparent enlargement of stromal cells. IUD in place 33 months.



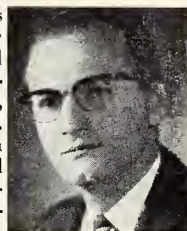
Fig. 3. Electron micrograph of postovulatory endometrium, showing topographic relation of glycogen (GL) to mitochondrion (arrow). IUD in place for 34 months.

Ultrastructural effects. The first three published electron microscopic studies of the endometrium appeared in 1967. Anclá and co-workers,¹ in a report of the effects of plastic devices in 20 specimens obtained by endometrial biopsy, described platelet-like thrombi of the small capillaries, a lesion that they termed "aneurysmal microthrombosis." Suggesting that the aneurysm leads to excessive uterine bleeding and that the extension of ischemia disturbs endometrial metabolism, they postulated that focal necrosis liberates thromboplastin, which activates coagulation.

To study the tissue that clings to the device, Potts and Pearson¹³ sectioned the IUD itself and found adherent collagen and an amorphous deposit. They suggested that mechanical damage to the uterine epithelium over limited areas, accumulation of cells and extracellular material in the uterine lumen, and alterations in luminal shape may play a part in the action of the IUD.

In electron microscopic studies from our laboratory,^{20,21} we described an asynchronous and premature cyclic development of the endometrium in response to IUD's. The ultrastructure of each specimen was

Ralph M. Wynn, M.D., is Professor and Head of the Department of Obstetrics and Gynecology, University of Illinois at the Medical Center, College of Medicine. Dr. Wynn received his M.D. from New York University School of Medicine. His field of interest is placental ultrastructure and function.



compared with that of its own control, which was obtained by endometrial biopsy before insertion of the device.^{22,24} Because of alterations in the pattern of uterine bleeding, we did not rely on menstrual histories but dated the endometrium solely by histological criteria. In both experimental and control endometria, different stages of development were often found in the

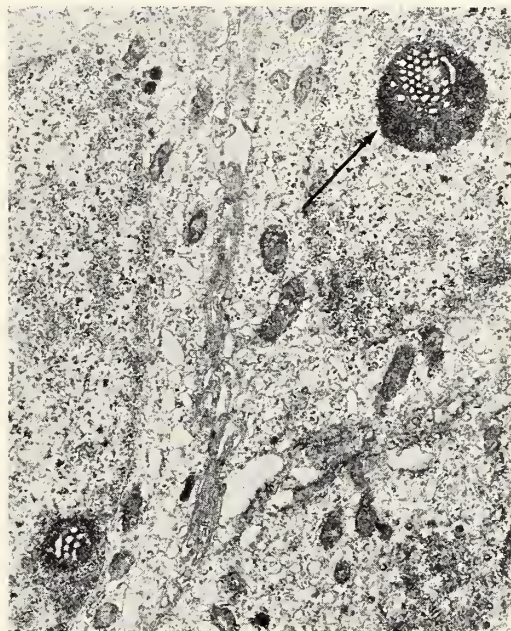


Fig. 4. Late proliferative endometrium, showing nucleolar channel system (arrow). Lippes loop in place.

same specimen. In each case we dated the biopsy according to the most advanced consistent pattern. Our conclusions were based on the assumption that the biopsy provided adequate information about the stage of the endometrial cycle. Nevertheless, we found typical nucleolar channel systems (NCS's) and other ultrastructural characteristics of the normal secretory phase (Fig. 3) in individual endometrial glands that were histologically proliferative (Fig. 4). Specifically, we observed giant

mitochondria and well-defined subnuclear patches of glycogen in endometria that were histologically proliferative. These fine-structural features were absent from the proliferative endometrial control specimens. Although the role of ovarian steroids in the development of the NCS is poorly defined, the nucleolar channel system is presumably related to the synthesis of nucleic acids. The appearance in the proliferative phase of ultrastructural changes associated with ovulation or exogenously administered hormones, and the occurrence of predecidual features several days prematurely, therefore suggest an alteration in endometrial maturation.

To correlate more accurately the morphologic and biochemical alterations produced by the IUD, we attempted an enzyme-ultracytochemical study of the endometrium.^{16,23} Thus far, we have been able to localize the distributions of several enzymes during the normal endometrial cycle. Studies of acid phosphatase, alkaline phosphatase, and glucose-6-phosphatase (Fig. 5) have already been reported. The next goal of our study is to ascertain whether the patterns of distribution of these and other enzymes are altered by the presence of the IUD.

Site of action. Upon which phase of the reproductive process the IUD exerts its primary effect is still not clear, but the premature and asynchronous maturation of the endometrium must be assumed to affect the precise correlation with ovular development that is required for normal implantation. In showing that the IUD may create an environment unfavorable for blastocystic attachment, these electron microscopic studies suggest that this potentially valuable method of control of fertility is contraceptive or contranidational rather than abortifacient in the usual sense.

Kelly and Marston⁸ repeated some of the earlier work that suggested accelerated transport of ova through the oviducts as the basis for contraceptive action. They were careful to use regular cycling macaques instead of superovulated animals. In their experiments, they found no differences between the monkeys bearing IUD's and the controls in the incidence of ovulation or fertilization or in the recovery of eggs; they therefore concluded that the device does not increase the speed of tubal

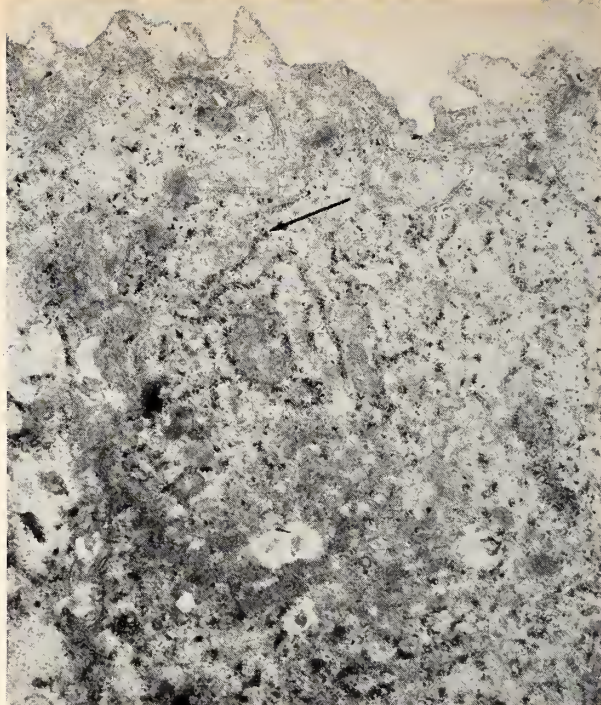


Fig. 5. Electron micrograph of endometrium around the time of ovulation. Tissues prepared to show positive reaction for glucose-6-phosphatase in endoplasmic reticulum (arrow).

transport. Kelly and Marston suggested, furthermore, that fertilized eggs enter the uterus normally and either degenerate rapidly or undergo premature expulsion. They postulated that in women also, tubal transport may not be affected by the IUD, the site of action of which was probably the uterus.

Parr and co-workers,¹² supporting the concept that the foreign body creates a hostile uterine environment, stress the role of inflammation in direct toxicity on blastocysts or spermatozoa. They found that lyszyme, which indicates inflammation, was present in polymorphonuclear leukocytes but not in normal uterine washings. They therefore concluded that some substance derived from white blood cells may exert a toxic effect on fertilized ova or spermatozoa and may thus be the cause of the infertility produced by foreign bodies. They offer the interesting speculation that since polyethylene devices produce only slight inflammation in women, they may not provide optimal contraception. Their work was performed in rats, mice, and rabbits, however. In view of the wide interspecific differences in mode of action of intrauterine foreign bodies, it is therefore crucial to repeat these important experiments in

women, or at least in monkeys, before equating contraceptive effectiveness with extent of inflammatory reaction.

Future of the IUD. There is no doubt that intrauterine devices are an important, effective method of population control. There is even less doubt that further research is needed to ascertain their mode of action, to prove the absence of long-term adverse effects, and to design better models with fewer complications. The present status and the future of the IUD's were authoritatively summarized by McGeorge Bundy, president of the Ford Foundation, in *The New York Times*, November 6, 1967: "Despite the remarkable record of safety and effectiveness, neither the presently available oral contraceptives nor intra-uterine devices are ideal for all users. The need remains high to speed development of promising but unexploited methods on which basic research has been completed."

Bundy's charge is presently being met by the production of new combinations of steroids in increasingly small doses with fewer side-effects and of IUD's of improved design. In fact, several laboratories in this country within the last year have reported preliminary experience with a combined form of contraception in which an intravaginal device is impregnated with a slowly-released steroid. Mechanical and hormonal contraceptives are thus combined to create a method of population control that may have fewer and less serious complications than those of either method alone. There is every reason to believe that the contraceptives presently in use will be continuously replaced during the coming years by a new "generation" of compounds and devices with better understood mode of action and greater use-effectiveness. ◀

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Report of Accidental Poisoning Death From

Fluid Extract of Ipecac

BY NORMAN J. ROSE, M.D., M.P.H./SPRINGFIELD

Although Syrup of Ipecac is now recommended by most medical authorities as the emetic of choice in accidental poisoning cases, the danger of substituting Fluid Extract of Ipecac has also been recognized, and the recommendation made that Fluid Extract of Ipecac not be dispensed.

The danger of such substitution is shown in the following summary of history of death in a child who was mistakenly given Fluid Extract instead of Syrup of Ipecac.

A 19 month old Illinois child ingested the heads from one-half book of matches. A pediatrician was called and ordered a prescription of Ipecac sent to the residence. A 2 oz. bottle, carrying the label of "IPECAC" only, was received. No instructions for dosage were shown. The contents were later identified as Fluid Extract of Ipecac, rather than Syrup of Ipecac.

Three spoonfuls were administered but after noticing that vomiting was not induced, two more teaspoonfuls were given—the mother later stated that about 2 teaspoonfuls were vomited. The tincture was blackish according to the mother. The child was admitted to the hospital. Symptoms included: shock, lethargy, diarrhea, dehydration, convulsions, cardiorespiratory distress, pneumonia.

The child died on the third day—with diagnosis—"Presumed toxic state due to ex-

cess ingestion of tincture of Ipecac" and "Pneumonia."

Organs were submitted to the State Laboratory for toxicological examination. The results of this analysis revealed no evidence of sulfur, lead or zinc. Emetine-like substance was detected as follows:

1. Emetine (kidney basic fraction)
2.66 mg%
2. Emetine like or detoxification product
4.4 mg%
3. Reserpine type (related to Emetine)
—trace

According to the State Toxicologist, a summary of the clinical pathological and toxicological findings showed that death was due to:

- 1) Shock
- 2) Associated with acute dysentery
- 3) Emetine intoxication

This account of death in this young child should impress upon physicians, hospitals and pharmacists the importance of prescribing and dispensing *Syrup* of Ipecac as an emetic for poisoning, and should alert them to follow the recommendations that Fluid Extract of Ipecac not be kept in the pharmacy.

Let not carelessness in the selection of drugs for treating accidental poisoning lead us to further poisoning of poison victims. ◀

Report of Fatality

Spider Bite (*Loxosceles*)

A three-year-old, white, male was admitted to the hospital at 11:40 a.m.; attended by two physicians; patient had been in one of the physician's offices minutes before admission to hospital, complained of hurting of shoulder—had temperature 104°F.—red throat—had a spider bite and blister in left supra clavicular region, which had broken down; area was bluish, discolored and swollen. The child was active the day before and playful on the morning of admission to hospital—had vomiting during night. Child reached the hospital floor at 11:45 a.m.; complexion was dusty—no pulse—gasping respirations were noted. Mouth to mouth resuscitation was done—bloody involuntary urination, which was not present previously—nail beds were blue—11:50 a.m.—1-cc of Decadron I.M. and Terramycin were administered. Pronounced dead at 11:52 a.m.

Norman J. Rose, M.D., M.P.H., is Chief, Bureau of Hazardous Substances and Poison Control, Illinois Department of Public Health. He received his medical degree from Northwestern University Medical School, served his internship at West Suburban Hospital, Oak Park, and received his Master of Public Health degree from the University of Minnesota. He is a Diplomate of the American Board of Preventive Medicine.

Post Mortem: Frothy—bloody mucous from nose, swelling on left side half way between the acromion and angle of the jaw with bluish discoloration and small epidermal defect. The subcutaneous tissue beneath it as well as some muscle tissue appear edematous. No skin rash.

Summary: Death most likely caused by bite of Recluse Spider. (Child told mother he was bitten by a spider in the bed; mother did not see spider; however a *Loxosceles Reclusus* spider was found in the home.) ◀

Hospital Costs will be about \$100 per day in 1973, according to projections by the American Hospital Assn. George W. Graham, M.D., president of AHA, told the House Ways and Means Committee that the average cost of a day's stay in the hospital is now \$67.59, an increase of more than \$7 in the last year. Next year, he said, the cost is expected to rise to \$74.24. It will be \$98.37 in 1973. Dr. Graham gave these reasons: Medicare program, increasing salaries, rising expenses, general inflation.



THE VIEW BOX

BY LEON LOVE, M.D.

*Director, Department of Radiology, Loyola University Hospital
and Chairman, Department of Radiology, Loyola University
Stritch School of Medicine*

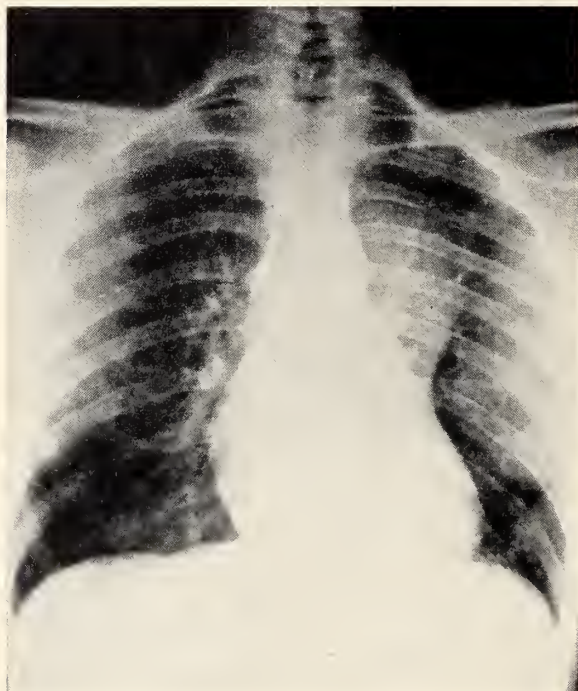


Fig. 1

This 31 year old male entered the hospital with a complaint of chest pain of two weeks duration accompanied by cough and a mild degree of fever. Physical examination revealed tenderness over the anterior chest wall and decreased breath sounds over the left upper lobe and dullness to percussion. What's your diagnosis?

1. Thymoma
2. Carcinoma of the left upper lobe with atelectasis
3. Extrapleural hematoma
4. Dermoid

(Answer on page 464)



Fig. 2

R: Give Your Patients **FACTS** On Medicare & Medicaid

CHARGE:

A recent Senate Finance Committee staff report said more than 4,300 doctors and 900 groups received \$25,000 or more from Medicare in 1968. Isn't this profiteering?

YOUR ANSWER:

Definitely not! The report distorted the facts by failing to point out that:

(A) Many of the doctors the government claimed earned more than \$25,000 had actually signed the bills for *all* the doctors in their clinic or hospital, as authorized by Medicare law. The \$326,000 that supposedly went to a Colorado doctor actually was the total of all fees paid to 124 doctors at Colorado General Hospital, an average of \$2,600 per doctor;

(B) Total earnings for groups also were not broken down. For instance, a California clinic was paid \$915,000 in Medicare fees in 1968. The report failed to make clear the money went to 130 physicians, an average of \$7,000 each, and the clinic is located in a retirement center serving three homes for the elderly;

(C) Indeed, elderly patients make up a substantial portion of the practices of doctors who earn \$25,000 or more from Medicare;

(D) The \$25,000 some doctors earned under Medicare was only gross income, and after paying overhead expenses, these doctors netted less than \$10,000 from Medicare;

(E) There are almost 200,000 practicing physicians eligible to treat Medicare patients, and the 4,300 figures cited in the report means about 97 percent of eligible physicians grossed less than \$25,000 under Medicare in 1968.

Source: Senate Finance Committee Staff Report; Social Security Administration records; independent studies of physicians' incomes and expenses.

CHARGE:

Some doctors use Medicare as a license to steal.

YOUR ANSWER:

False! Since the Medicare program began three and a half years ago, only two doctors—that's right—TWO doctors have been convicted of fraud. No action has been taken following investigation of fraud charges in 63 other cases. So that's two doctors convicted of the estimated 200,000 treating Medicare patients. What other profession can claim an honesty quotient that high?

Source: Senate Finance Committee Report; SSA and Department of Justice records.

Doctors get the biggest share of the Medicare dollar.

CHARGE:

YOUR ANSWER:

False! In fiscal 1968, doctors received only 23 cents of each Medicare dollar. Much of the remainder went to hospitals (64 cents) and nursing homes (6 cents).

Source: Social Security Bulletin, "National Health Expenditures."

CHARGE:

YOUR ANSWER:

Doctors are primarily to blame for runaway Medicaid costs.

False! Doctors earnings were even less under Medicaid than Medicare. During fiscal 1968, doctors received only 11 cents of the Medicaid dollar. Hospitals and nursing homes received 68 cents, druggists 7 cents, and other health services 7 cents.

Source: Social Security Bulletin, "National Health Expenditures."

CHARGE:

Doctors can charge whatever they please under Medicare and Medicaid, so a ceiling on doctors' fees would halt rising costs.

YOUR ANSWER:

Both statements are false. Ceilings were placed on doctors' fees for both Medicare and Medicaid on January 1, 1969, but have had no appreciable effect on rising health care costs. The latest available figures show total cost for both programs went from \$8.9 billion in fiscal 1968 to \$11 billion in fiscal 1969, an increase of 23 percent. During the same period, all payments to physicians *dropped* from 18.9 percent of total expenditures under both programs to 18.1 percent.

Source: Senate Finance Committee Report, Social Security Administration research and statistics.

CHARGE:

Over the years, doctors' charges have increased much more than fees for other goods and services.

YOUR ANSWER:

False! In 1969 the average doctor charged 38 percent more for an office visit than in 1964. During the same period a plumber charged 40 percent more for replacing a sink. The charge for repainting a room jumped 50 percent and the charge for a semi-private hospital room jumped 83 percent.

Source: U.S. Department of Labor, Bureau of Labor Statistics.

CHARGE:

Last year Medicare cost a whopping \$5.3 billion—twice as much as the Johnson administration predicted in 1965. Former Health, Education & Welfare director Wilbur Cohen says medicine is to blame.

YOUR ANSWER:

Mr. Cohen and his Washington cohorts are trying to cover up their own faulty fiscal predictions. In 1965 Congress *DID* estimate Medicare would cost only about \$2 billion a year—an estimate designed to please the public as voters without scaring them as taxpayers. The AMA warned it would cost about \$5 billion a year—and it was right! In fiscal 1968, Medicare cost \$5.3 billion, and in fiscal 1969 it cost \$6.5 billion. The economic reality is that Medicare created steadily rising demands for medical services with no increase in the medical personnel who supply those services. Following the inexorable law of supply and demand, prices went up. Now the government wants to avoid any blame by picking a whipping boy—doctors!

EDITORIALS



WHO ARE YOU?

Who are you?

An organization usually has two types of members—those who perform the necessary chores and those who belong for a variety of reasons, but seldom make known their views. Perhaps this is as it should be. After all, each person places a different value on similar items or activities, and not everyone has the time to help run an organization.

Lately we have heard quite a bit about the “silent majority.” This group, apparently, is taking a greater interest in the multifaceted problems facing our country today. Some are showing an active interest; others are merely exhibiting an expression or an awareness of the problems at hand. The sheer volume of interests and priorities makes it impossible for any individual to be involved in more than a few projects.

Another reason people do not become involved may be that, by nature, we tend to be vulnerable, so we retreat; we go into our cocoon of security. Perhaps we are afraid of being rejected.

Professional medicine is being challenged—seriously challenged—as we begin a new decade. Malpractice, peer review, cost control, gouging, reasonable and proper, and a myriad of other terms deeply trouble us. We are incensed because we feel put upon.

It is surprising how many United States senators and representatives base their decisions (votes) on letters from their constituents. The lawmakers have no way of knowing whether these letters came from people who voted for or against them. In our opinion, much of this correspondence represents pressure politics and is written by people encouraged to do so by individuals with vested interests.

The silent majority are the losers when their congressmen will not think for themselves and make decisions only via letters from “my constituents.” As much as we dislike this method of running a country, there is no alternative. Physicians must make their opinions known *now* or forever remain silent. Many bills about to be introduced into congress will radically influence the practice of medicine. Your opponents will not be mute and neither should you. Our state medical society, likewise, must be aware of the needs of the members via direct communication.

To idly sit by and woefully wring our hands when not in agreement will solve nothing. We must become involved—at the county, district, state and national levels. Involved through collective action. The county medical society, state medical society, IMPAC, and similar groups, are most effective. And, these bodies can be more effective if concerned members participate actively. You are an important brick in the building of professional medicine. Your opinion and your participation are needed.

One place to learn more about what is happening along these lines is at your annual convention, May 17-20. What are you going to do about it? Will you attend and lend your support? Have you participated in the educational seminars? If you cannot attend, have you made sure that you will be represented?

Or—will you be a member of the silent majority?

R.A.O.

ECHOCARDIOGRAPHY

Biomedical instruments may soon vie with the X-ray and electrocardiograph as diagnostic tools. Ultrasonic equipment, for example, has been refined to the point of being of value in the clinical evaluation of a number of cardiac, obstetrical, and abdominal conditions. Ultrasonic echoes, similar to those used to measure the depth of the ocean or lake, can be plotted in the form of blips on a cathode ray.

Bursts of ultrasonic waves from a transducer are aimed at various parts of the heart. During the fraction of a second between bursts, the same transducer acts as a receiver to pick up the sound echoes coming from tissues of different acoustical impedance. The echo patterns are recorded on a screen (echocardiogram) and various normal and abnormal patterns have been established. It is now possible to detect mitral stenosis in this way and to differentiate combined mitral stenosis and regurgitation.

Alterations in the pattern also have been found when the heart is enlarged, in pericardial effusion, aortic aneurysm, congenital lesions, atrial tumors and thrombi, pleural effusion, and pulmonary embolus.

Considerable skill is required to use the equipment and to interpret the findings.

An adequate echo pattern may be difficult to obtain because of obesity, cardiac displacement, scar tissue from previous surgical procedures, and emphysema. The ultrasonic waves are conducted through the body via body fluids and are extremely sensitive to slight changes in tissue density. Wave forms from valve leaflets may vary considerably from cycle to cycle. The movement of the interventricular septum or chordae tendineae may be confused with that of the anterior mitral valve leaflet.

Ultrasound is also used in diagnosing space-occupying lesions of the brain and various ocular conditions such as retinal detachment, tumors, and foreign bodies. The technique differentiates between soft tissue and cystic masses of the kidneys, liver, pancreas, spleen, and the mediastinum. Since sound waves are harmless they can be used to follow the progress of pregnancy including the measurements of the head of the fetus.

Biomedical engineering is still in its infancy and there are many other devices now in use or in the experimental stage. Thermography, flexible fiber optics, sound spectrographs, improved spirometry, and monitoring equipment are but a few now available.

T. R. Van Dellen, M.D.

Meany: Wages Based on Productivity

"The American Federation of Labor has never agreed to the principle of basing wages on cost of living or on price inflation. The established wage policy of this country has always been based on raising wages as increases in productivity made this possible. This is the only possible basis for an expanding economy with rising living standards."—AFL-CIO president George Meany in 1945 when he was secretary-treasurer, AFL.

America by the Numbers

Listing our national assets, Secretary of Commerce Maurice H. Stans points out that we have 203,000,000 Americans who:

- Live on three per cent of the earth's surface.
- Produce nearly one trillion dollars in goods and services.
- Earn \$756 billion.
- Spend more than half a trillion dollars, \$3 billion of it on recreation and leisure.
- Save \$33 billion.
- Drive 100 million cars.
- Watch 75 million television sets.

Prolapsus Uteri With Pelvic Kidney

BY VINCENT S. DIGIULIO, M.D./JOLIET

Pelvic relaxation is usually best treated by vaginal hysterectomy and repair. However, in the presence of renal ectopia one must vary the surgical management in order to prevent damage to the kidney and ureter. In the following case the left kidney was directing opposite the cervix uteri and impressing the left lateral fornix of the vagina. Hence, the condition was treated by abdominal hysterectomy and anterior and posterior repair.

In the post-operative period, the bladder was subjected to exercise to restore function when the indwelling catheter was removed. The usual routine for this is to instill 300 cc of sterile water into the bladder and leaving it in for 15 minutes t. i. d. the third and fourth post-operative day and 30 minutes on the fifth post-operative day. After the third installation on the fifth day the Foley is removed and the patient is given 3 to 6 cans of beer. This relaxes the patient and fills the bladder. Voiding is thus easily accomplished.

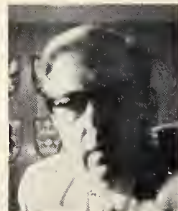
Case Report

A 34-year-old Caucasian female complained of menorrhagia, stress incontinence

of urine, vaginal pressure and frequent urination. Celiotomy in 1960 revealed left renal ectopia (Fig. 1). Her past history revealed four full-term pregnancies and appendectomy at age 11. A physical exam revealed a second-degree uterine prolapsus, large cysto-coele and rectocoele. The impression of the kidney is in the left lateral fornix (Fig. 2). Intra-venous pyelogram revealed the left kidney to be in the true pelvis (Fig. 1). Routine lab work was normal.

The patient was treated by cystoscopy for fibrous urethritis and then by abdominal hysterectomy and anterior and posterior repair. The patient had a good recovery.

Vincent S. DiGiulio M.D., F.A.C.S., is a Joliet obstetrician and gynecologist. A graduate of the University of Illinois, College of Medicine, he is an assistant clinical professor of OB-GYN at the University of Illinois, College of Medicine. Dr. DiGiulio is a Fellow, American College of OB-GYN and Diplomate, American Board of OB-GYN.



Discussion

Solitary renal ectopia occurs once in 2200 cases and is three times more common on the left side. In my experience, I have never heard of the combination as described in this case and hence believe that this is an original case.

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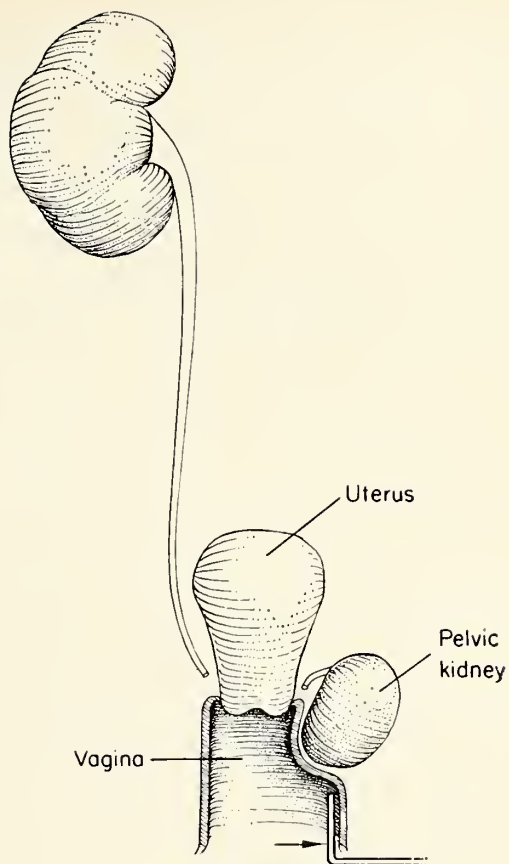


Fig. 1. Frontal View

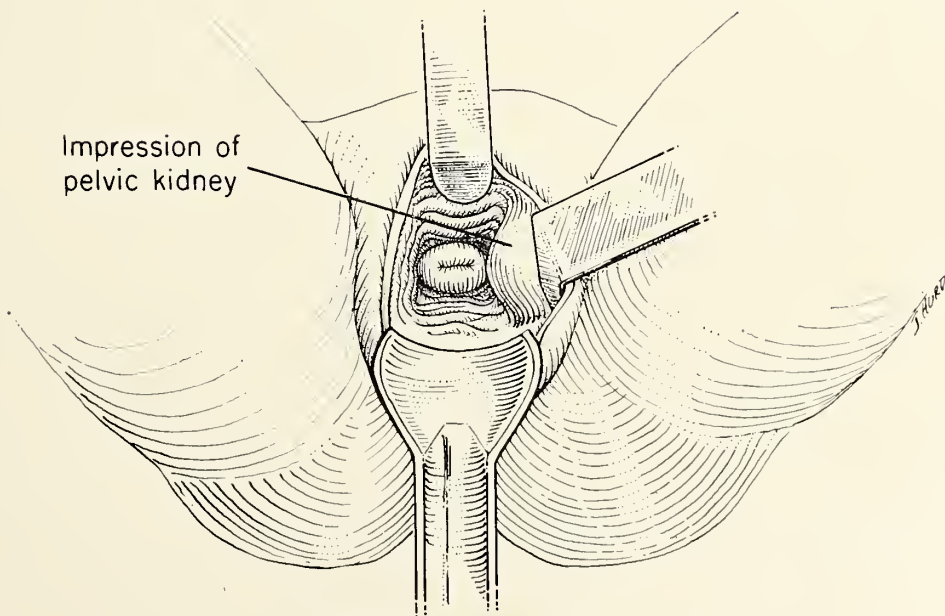
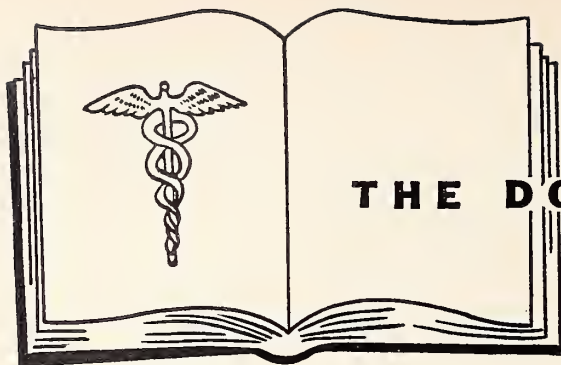


Fig. 2. Lithotomy View



THE DOCTOR'S LIBRARY

MEDICAL SUPPLY IN WORLD WAR II, The Historical Unit, USAMEDS. Walter Reed Army Medical Center Superintendent of Documents, Government Printing Office, Washington, D.C. 20402. (1968) Price \$8.25.

The magnitude of the medical supply operation in World War II is portrayed in this book. The account is based on hundreds of documents, reports, correspondence, directives, and statistical records, and on the recollections and personal narra-

tives of scores of individuals who participated in the various supply activities, at home and in the theaters of operation. Medical supply personnel around the world provided the means of treating and caring for some 14 million hospital patients and of dispensary cases beyond counting.

There are 662 pages with 149 illustrations, 54 maps, 8 tables, and a comprehensive index.

T. R. Van Dellen, M.D.

THE CARE OF THE GERIATRIC PATIENT. Edited by Edmund Vincent Cowdry, Ph.D., ScD., 3rd Edition, 430 pages, 19 illustrations. C. V. Mosby Co., St. Louis, 1968.

The third edition of this book now contains several new chapters and many others that have been rewritten or updated. It is a definite improvement over the original editions. Many of the 38 contributors are nationally known physicians, dentists, social workers, nurses, and clergymen.

The 28 chapters cover a variety of subjects related to the elderly patient. Disease states and physiologic changes peculiar to the geriatric patient are discussed from the

diagnostic and therapeutic aspect. Sections devoted to the medical, psychiatric, and psychological aspects of aging are excellent and should prove most helpful.

The last part of the book contains material not taught in medical schools or hospitals. These are the chapters discussing nursing care, selection of nursing homes, and home care. In addition, there is an up-to-date evaluation of current Social Security laws and how the physician and patient may best use them. An extensive bibliography listing hundreds of references adds to the value of the book.

T. R. Van Dellen, M.D.

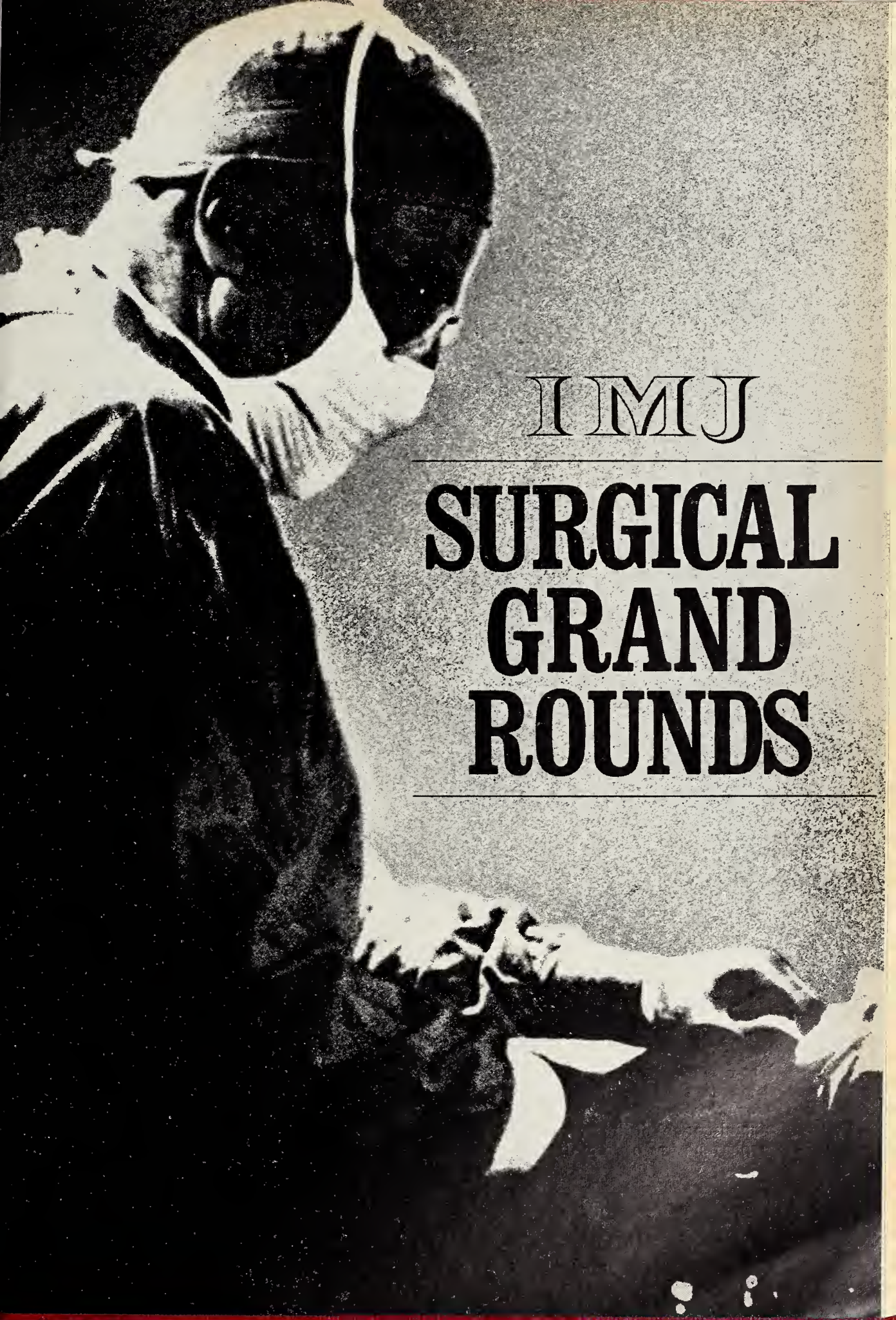
MEDICAL LABORATORY TECHNOLOGY AND CLINICAL PATHOLOGY. Edited by Matthew J. Lynch, M.D., Stanley S. Raphael, M. B., Leslie D. Mellor, Peter D. Spare, and Martin J. Inwood. W. B. Saunders Company, 1,359 pages, 1969.

This is the second edition of this Canadian text on clinical pathology. The book is divided into sections on chemical pathology, hematology, microbiology and histological techniques. In these sections, new chapters have been introduced on immunoglobulins, inborn errors of metabolism, virus and rickettsial disease and cytogene-

tics. The section on the histologic techniques, over 200 pages long, is excellent, but in this country the subject would not usually be considered part of clinical pathology. Increase in sophistication has accompanied increase in size.

There is considerably more clinical pathology correlation, more physiology, and more discussion of "why" as well as "how" in relation to laboratory procedures. This makes the book useful for medical students and pathologists as well as medical technologists.

Joseph C. Sherrick, M.D.



IIIMJJ

SURGICAL GRAND ROUNDS

Epiphrenic Diverticulum of the Esophagus

Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on November 15, 1969.

EDITED BY JOHN M. BEAL, M.D.

Case Report

Dr. Arthur Palmer: A 59-year-old white man was admitted to the Veterans Administration Research Hospital and complained of severe dysphagia, regurgitation of food and weight loss of six months' duration. His weight, which was normally 200 pounds, was 140 pounds at the time of admission. For two months oral intake had been limited to small quantities of liquids. When he ate a small amount of food, he regurgitated it promptly. This was not associated with pain or hematemesis. He stated that slight dysphagia began one year before admission.

When examined, he was moderately dehydrated and had signs of a right lower lobe pneumonitis. His admission laboratory values revealed an elevated BUN, which promptly returned to normal following the administration of intravenous fluids. An esophagram was performed.

Dr. Stanley Hoover: A plain film of the chest was taken first and demonstrated a density behind the heart on the left side of the thorax. When barium was swallowed, a collection of barium, 5 x 8 cm., was found extending from the left side of the distal portion of the esophagus (Fig. 1). A spot film showed that there was an air-fluid level in this area. Another spot film showed the passage of barium through the neck of the diverticulum. The remainder of the esophagus appeared normal.

The esophago-gastric junction appeared to be at the level of the diaphragm and evidence of a hiatus hernia was absent. The lumen of the esophagus was normal distal to the diverticulum.

The first of three chest films was taken soon after admission and a patchy infiltrate was found which appears to be in the right middle lobe (Fig. 2). This finding per-



Fig. 1. The diverticulum is seen best on the lateral view.

sisted in the film taken one week later and a partial collapse of the medial segment of the right middle lobe was evident. The third chest film was obtained ten days after operation and partial clearing of the right middle lobe infiltrate had occurred.

Dr. Palmer: Following esophagoscopy, a nasogastric tube was successfully passed into his stomach and tube feedings were begun. His aspiration pneumonia cleared rapidly. After five weeks of tube feedings, he was subjected to operation.

Dr. Sidney Haid: Esophagoscopy was performed with care because the barium swallow indicated that the direct pathway was into the diverticulum rather than down the esophagus. Endoscopy was undertaken to determine if there was obstruction distal to this diverticulum. The esophagoscope passed easily into the stomach, although the esophageal lumen was diverted to one side by the size of this diverticulum.

After his pneumonitis resolved and his nutrition improved, the patient was taken to the operating room. The diverticulum was found in the lower portion of the esophagus. It was dissected free from the esophagus and was opened. The neck of the diverticulum was identified and the lumen of the esophagus was clearly visualized. The diverticulum was then excised and the esophagus was closed.

Dr. Joseph Sherrick: Sections through the wall of the diverticulum show that the stratified squamous epithelium lining is slightly thickened, and there are lymphoid

foci in the submucosa. The wall is composed of rather dense fibrous connective tissue, with a few smooth muscle bundles representing the muscularis mucosa. The usual circular and longitudinal muscle bundles are entirely absent, indicating that this is a false diverticulum, possibly representing herniation through a defect in the muscular layers. These are the usual anatomical findings in epiphrenic diverticulum. **Dr. Haid:** The patient did very well postoperatively. He began feeding with liquids on the tenth postoperative day. He rapidly progressed to a full diet and was discharged without dysphagia.

There are three types of esophageal diverticula: the pharyngoesophageal, the parabronchial or traction, and the epiphrenic. The last is the least common and

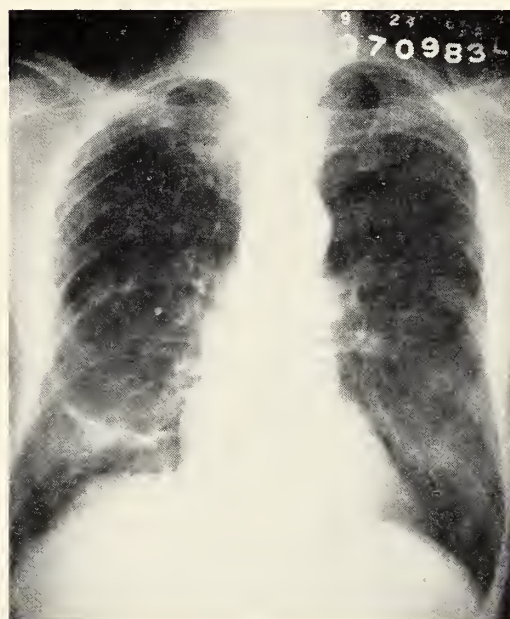


Fig. 2. The chest film demonstrates patchy infiltration in the lower right lung field.

probably accounts for approximately ten per cent of all esophageal diverticula.

The first epiphrenic diverticulum was reported in 1804 by Deguise. Probably the first esophageal diverticulum was described by a Mr. Ludlow in 1764, who wrote a letter to William Hunter concerning a "case of obstructed deglutition from a preternatural dilatation of a bag formed in the pharynx."

Wheeler, in a study of 20,000 barium swallows, found an incidence of 0.015 per

cent of epiphrenic diverticula as compared to 0.3 per cent traction and 0.1 per cent Zenker's diverticula. Haben studied 201 cases of epiphrenic diverticula and found an age range of thirty-eight to seventy-three, with an average age of fifty-three years. There was a slight male sex preponderance.

The etiology of these lesions is not settled. It has been shown that the weakest point in the esophagus is a few centimeters above the diaphragm, where the longitudinal muscle fibers start to spread out to join with the fibers of the stomach. This is the location where most epiphrenic diverticula occur. Thus they may be caused by disorders of esophageal motility and therefore may be pulsion diverticula. Indeed, achalasia has been associated with epiphrenic diverticula. Other reported co-existing conditions are hiatus hernia, diffuse esophageal spasm and stricture associated with peptic esophagitis. From 65 to 80 per cent of patients have been reported to have other disease. Among other associated conditions which are seen with epiphrenic diverticula is carcinoma of the esophagus. There have been three cases of carcinoma reported in the esophageal diverticulum. Two cases of benign tumors in the esophageal diverticulum, one myxoma and one fibroma, have been reported. Perforation occurs rarely.

Approximately one-third of these patients are asymptomatic. Others have symptoms of dyspepsia, dysphagia and regurgitation in varying severity. The regurgitation can give rise to respiratory symptoms such as chronic bronchitis or pneumonitis. Occasionally, hematemesis occurs.

The diagnosis of epiphrenic diverticulum is established by X-ray. Endoscopy is helpful to determine if other disease is present. The diverticula are located in the posterior wall of the distal esophagus, five to ten centimeters from the cardia, and usually present to the right side. As Dr. Sherrick has mentioned, these are false diverticula.

Treatment is reserved for patients with symptoms. For mild symptomatics, weight reduction, elevation of the bed, and small meals may help. The history of surgical treatment begins in 1906 when Roux removed an epiphrenic diverticulum which, interestingly, appeared below the diaphragm and was removed at the time of laparotomy. Lotheisen in 1908 attempted

an anastomosis of the diverticulum to the stomach. Stierlin used a transthoracic approach in 1916; unfortunately, the patient developed empyema and expired. Willy Meyer is credited with the first successful transthoracic removal of a diverticulum.

Almost all of these diverticula are now approached through a left thoracic route regardless of the direction in which they present, because the associated disease can be better dealt with through a left thoracotomy. If a hiatus hernia is present, it should be corrected. If achalasia is present, esophagogastric myotomy, the Heller procedure should be performed. Allen and Clagett advise myotomy in all cases of epiphrenic diverticulum, whether they can prove achalasia or not. They have reported a reduced mortality and morbidity rate by this method.

The most common postoperative complications are leak from the suture line, recurrence or aspiration at the time of operation.

Dr. Thomas Shields: The major evaluation on these patients, as far as I am concerned, is to determine how much the patient's dysphagia is due to the presence of the diverticulum. In a third of the patients that we have seen, the presence of the diverticulum was the major cause. In the patient presented today it was the only etiology of the patient's difficulty in swallowing. However, in all these patients, it is paramount that we rule out hiatus hernia or achalasia preoperatively so that if either is present it may be corrected at the time of operation. If there is failure to recognize and correct such associated lesions as noted by the Mayo series, there will be an inordinately high percentage of these patients who will develop a leak at the anastomosis following the operative procedure.

Our own series is relatively small since this is really an uncommon lesion. In only one patient was there the presence of an associated achalasia. In fact, the patient had multiple diverticula of the esophagus and the patient's difficulty in swallowing was primarily due to the achalasia and not to the diverticula. In no patient was there an associated hiatus hernia. In none of these patients, except the one with achalasia, did we perform any operative manipulation of the esophagogastric junction. It is my be-

lief that one of the major things to be avoided is manipulation of the hiatal mechanism, if at all possible. If it is already damaged, certainly it must be corrected but don't create any possible postoperative problems unnecessarily. If injury to the mechanism occurs, postoperative regurgitation, esophagitis and subsequent stricture may develop.

After resection of the diverticulum, we repair the wall in two layers; no effort is made to reinforce the suture line. We test it for leakage by injecting air into the esophagus with the pleural space filled partially with water. If this shows no leak, the chest is closed in the usual manner. The area is drained by the usual closed waterseal method. ◀

Clinics for Crippled Children Scheduled

Twenty-five clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois, Division of Services for Crippled Children. The Division will conduct twenty-one general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be three special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

May 5—Pittsfield—Illini Community Hospital
 May 6—Hinsdale—Hinsdale Sanitarium
 May 7—Sterling—Community General Hospital
 May 7—Effingham—St. Anthony Memorial Hospital
 May 7—Litchfield—Madison Park School
 May 8—Chicago Heights Cardiac — St. James Hospital
 May 12—Peoria—St. Francis Children's Hospital
 May 12—Fairfield—Fairfield Memorial Hospital
 May 12—East St. Louis—Christian Welfare Hospital
 May 13—Champaign-Urbana — McKinley Hospital
 May 13—Joliet—St. Joseph's Hospital
 May 14—Macomb — McDonough District Hospital
 May 14—Springfield General — St. John's Hospital
 May 14—West Frankfort—UMWA Union Hospital

May 19—Rock Island Area General—Moline Public Hospital
 May 20—Evergreen Park—Little Company of Mary Hospital
 May 21—Rockford — Rockford Memorial Hospital
 May 21—Decatur—Decatur Memorial Hospital
 May 21—Elmhurst Cardiac—Memorial Hospital of DuPage County
 May 22—Chicago Heights Cardiac — St. James Hospital
 May 26—Peoria — St. Francis Children's Hospital
 May 26—East St. Louis—Christian Welfare Hospital
 May 27—Centralia—St. Mary's Hospital
 May 27—Elgin—Sherman Hospital
 May 27—Springfield Pediatric Neurology—Diocesan Center

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Rx Products Index

Achrostatin V 467 Lederle Laboratories	Mucomyst 326-327 Mead Johnson Laboratories
Ambar 314 A. H. Robins Company	Neosporin 318 Burroughs Wellcome & Co.
Aventyl HCL 324-325 Eli Lilly and Company	Neo-Synephrine 310 Winthrop Laboratories
Bayer Aspirin 323 Glenbrook Laboratories	Obedrin-LA715L 316 Semed Pharmaceutical Div., S. E. Massengill Co.
Dicarbosil 464 Arch Laboratories	Pro-Banthine 2nd Cover G. D. Searle & Co.
Dimetapp 319 A. H. Robins Company	Quinamm/AVC 321-322 National Drug Co.
Donnatal/Albee with C 461, 462 A. H. Robins Company	Sinequan 447-450 Pfizer Laboratories Div., Chas. Pfizer & Co.
Doxidan 315 Hoechst Pharmaceutical Co.	Tepanil 3rd Cover National Drug Co.
Ilosone 332 Eli Lilly and Company	Tetrex Bidcaps 454 Bristol Laboratories
Isoclor 329 Arnar-Stone Pharmaceuticals, Inc.	Thorazine 456 Smith Kline & French Labs.
Kantrex 331 Bristol Laboratories	Thera-Combex HP 309 Parke Davis & Co.
K-Lyte 452-453 Mead Johnson Laboratories	Urised 328 Conal Pharmaceuticals, Inc.
Librium 458-459 Roche Laboratories	Vasodilan CVD 312-313 Mead Johnson Laboratories
	Valium Back Cover Roche Laboratories

Obituaries

***Charles L. Bidwell**, Chicago, died March 3 at the age of 73. He had been assistant to the chief medical officer of the Illinois Central R.R.

***Edward J. Conlin**, Chicago Heights, died Feb. 7 at the age of 62.

***Roscoe C. Giles, Sr.**, Chicago, died Feb. 18 at the age of 79. He was a member of the ISMS Fifty-Year Club.

***Robert L. Holeombe**, Highland, died Jan. 23 at the age of 70. He was past president of the Madison County Medical Society.

***Leonard A. Kratz**, McHenry, died Feb. 19 at the age of 68. He was chief of surgery at Harvard Memorial Hospital.

***Edwin Netzel**, Lincolnwood, died Feb. 14 at the age of 50. He was on the Board of Directors of the Spastic Children Research Foundation.

Edwin J. Pulaski, Morton Grove, died in February at the age of 59.

***Arthur T. F. Remmert**, Chicago, died Feb. 14 at the age of 72.

***Ciney Rich**, Decatur, died Feb. 3 at the age of 78. He was past president of the Macon County Medical Society.

***Paul G. Tobin**, Elgin, died Feb. 4 at the age of 63. He was chief of staff at Sherman Hospital.

*Indicates Member of Illinois State Medical Society.



Membership Forum

February 13, 1970

Dear Sir:

Enclosed is a copy of a letter sent to Mr. Michael Youssi, a student at the University of Illinois.

His original inquiry appeared in our state journal.

Regards,

R. F. Barnes, M.D.

Dear Mr. Youssi:

Your letter, published in the January, 1970, *Illinois Medical Journal*, regarding the lack of exposure to general practice at our state university, strikes a responsive cord and deserves a frank reply.

Doctors in this state, many of whom are alumni of the University of Illinois, have been disturbed for years at the lack of communication between the University and the practicing physician. Many have felt the University has not been responsive to desires or medical needs of this state's citizens.

For a number of years a dedicated group of prac-

ticing physicians has repeatedly dealt with the University in an attempt to introduce its medical students to general practice. For years the school has turned a deaf ear. The general men have been able to get nowhere near the medical school nor its students.

After many years, and much frustration, a significant breakthrough has occurred. The Kane County Medical Society, using a format designed by the DuPage County Medical Society in its successful preceptorship program with Chicago Medical School, has established with the University a program for its students to be more widely exposed to general practice.

We have many physicians in our area anxious to participate in this program. We hope the University will give it proper publicity and exposure.

Sincerely yours,

R. F. Barnes, M.D.

Ed. note: Membership Forum is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.

The Tall State

Illinois houses the world's largest and busiest airport . . . O'Hare International Field . . . where as many as 2,000 aircraft movements a day are recorded, an average of three airplanes every two minutes for 24 consecutive hours. Twenty-five million airline passengers a year pass through Illinois.

Film Reviews

"Do's" and "don't's" for the medical assistant receiving and caring for patients in her physician's office is dramatized in "Case in Point," subtitled "Medico-Legal Responsibilities of the Medical Assistant." Designed primarily to avoid malpractice suits, the 16mm film, in sound and color runs for 25 minutes. It is available on free loan from: Wyeth Film Library, Box 8299, Philadelphia, Pa. 19101.

* * *

"The Unwanted Four," a color sound-filmstrip program, dramatizes food handling practices to protect against the four harmful bacteria that cause most outbreaks of foodborne illness; *Staphylococcus*, *Clostridium perfringens*, *Salmonella*, and *Streptococcus*. The film is available from the Educational Materials Center of the National Restaurant Association, 1530 N. Lake Shore Drive, Chicago, for \$10.00.

The story of the rehabilitation of a wounded Vietnam War veteran combines with the spectacular scenery of Alaska in a new motion picture entitled "The Open Road." The 27½ minute, 16mm color and sound film shows the rehabilitation work done in a military hospital and the therapeutic value of fishing. Prints can be reserved by contacting: Woodstream Corporation, Lititz, Pa. 17543.

* * *

After Advertising Is Censored. . . .

"If government can establish the right to censor advertising in the public interest, it can move toward control of news content."—Rep Clarence J. Brown of Ohio.

Meeting Memos

April 23—The Institute of Medicine of Chicago

Health Forum
"Pollution of Your Air and Water"
332 South Michigan Ave., Chicago

April 25—Augustana Hospital

Slide Seminar on Gynecologic-Pathology
Hektoen Institute, 627 South Wood Street, Chicago

April 26-30—Canadian Committee on Arrangements

First International Congress on Group Medicine
Winnipeg, Manitoba, Canada

April 28-30—IIT Research Institute

Symposium on International Advances in SEM Technology and Applications
10 West 35 Street, Chicago

April 30-May 1—Illinois Heart Association

Symposium on Sudden Death
Hotel St. Nicholas, 4th & Jefferson Streets, Springfield

May 1-2—Illinois Heart Association

IHA Annual Meeting and Delegate Assembly
Springfield

May 1-3—Phi Delta Epsilon Medical Fraternity

National Convention
The Drake Hotel, Chicago

May 4-5—American Cancer Society

12th Annual Western Cancer Seminar
Frontier Hotel, Las Vegas, Nevada

May 4-6—Tri-State Hospital Assembly

40th Annual Assembly
Palmer House, Chicago

May 5-7—Illinois TB-RD Ass'n. Annual Meeting

Ill. Thoracic Society—May 5—
St. Nicholas Hotel, Springfield

May 6-7—The Cleveland Clinic Educational Foundation

Postgraduate Course
"Progress in Cardiovascular Disease"
2020 East 93rd Street, Cleveland, Ohio

May 7-8—American Medical Association

3rd National Voluntary Health Conference
Statler-Hilton Hotel, Washington, D.C.

May 8-9—University of Kentucky College of Medicine

Symposium on Gastrointestinal Disease
Albert B. Chandler Medical Center, University of Kentucky, Lexington, Ky.

May 13-16—American College of Surgeons Chicago Committee on Trauma

Postgraduate Trauma Course
John B. Murphy Auditorium, 50 East Erie Street, Chicago

May 17-20—Illinois State Medical Society

Annual Meeting
Sherman House, Chicago

May 21-22—The Cleveland Clinic Educational Foundation

Postgraduate Course
"Advances in Dermatology"
2020 East 93rd Street, Cleveland, Ohio

May 21-23—Mound Park Hospital Foundation, Inc.

Postgraduate Course
"Pediatric and Adolescent Psychiatry"
Tides Hotel and Bath Club, St. Petersburg, Fla.

May 22-24—The Chicago Medical School

Symposium on Sex and Its Problems
Arlington Park Towers, Arlington Heights, Illinois

May 22-29—Internal Union Against Cancer

10th International Cancer Congress
Houston, Texas

How to Keep Budget in Balance

"The President's balanced budget won't stop a dime's worth of inflation unless the people insist that Congress hold the line against excessive spending. . . . If the budget is to stay balanced, the people will have to restrain themselves, their congressman and their senators. The President has done his job. The rest is up to us."—Arch N. Booth, executive vice president, Chamber of Commerce of the United States.

Guidelines for

Prescribing Physical Therapy

Widespread misunderstanding of physical treatment services reimbursable under Medicare and other third party sources prompted the ISMS Board of Trustees to approve guidelines to help MDs better prescribe and evaluate these services.

The guidelines, prepared by Dr. Henry B. Betts and Dr. Joel Rosen and their Committee On Rehabilitation Services, follow:

Requirements for Physical Therapy Services Reimbursable Under Medicare

1. The physician in communication with the physical therapist, must prescribe (authorize in writing) the specific means or methods to be used by the therapist and the frequency of therapy services.
2. Physical Therapy must be related to the active treatment regimen designed by the physician to elevate the patient to his maximum level of function which has been lost or reduced by reason of injury or illness.
3. "Physical therapy as needed" or a similarly worded blanket authorization does not suffice as an accepted prescription since no specific treatment is named and the physical therapist is in effect prescribing the patient's regimen.

Distinction Between Physical Therapy Services and Restorative Nursing Care

1. Restorative nursing care includes such measures as maintaining good body alignment and proper positioning of bedfast patients, keeping patients active and out of bed in accordance with the physician's orders, and developing the patient's independence in activities of daily living by teaching self-care, transfer and ambulation activities on the nursing unit.
2. Nursing personnel may also assist patients in practicing the use of prosthetic and orthotic devices and in carrying out the prescribed physical treatment if requested by the physician.
3. Restorative nursing procedures performed by licensed nurses constitute a part of skilled nursing care when they are prescribed by a physician and are designed

to restore functions which have been lost or reduced by illness or injury.

Recommendations When Prescribing All Physical Treatment Services

1. The physician should place detailed orders for all Allied Health Professions in the patient's chart prior to the treatment being initiated, specifying goals or potentials. This implies that the physician should designate the person or department to supply the physical treatment services, such as physical therapy, occupational therapy, nursing, etc.
2. The physician should ask the physical therapist, or others of the Allied Health Professions, to file notes in the patient's chart similar to nursing notes at least weekly, reflecting the patient's response to treatment.
3. The physician should review the patient's record at least every two weeks to determine if treatment is being provided according to his orders. Treatment that is being provided, but which has not been prescribed or authorized by the physician, should be discontinued immediately.
4. Formal physical and occupational therapy is not indicated when evidence indicates that similar types of care could be provided on the nursing unit by rehabilitative nursing or other techniques.
5. Over-utilization of health service is a problem which physicians, Allied Health Professions, and third-party sources realize exists. It is the responsibility of the physician to insure that proper treatment is provided but that unnecessary treatment and over-utilization of health services is avoided.

National Debt Trimmed in Early Days

The U. S. had a national debt even before the nation got started—mostly debts piled up by fighting the Revolution. But at least one of the early presidents—Jefferson—did something about reducing it. He backed the severe economy of his Secretary of Treasury, Gallatin, which was soon reducing the national debt by \$3 million a year—a lot of tax money in those days. But that much would be but a sliver in shaving the current national debt, which is somewhere around \$364 billion.

Looking for a Place to Practice?

Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

PERRY COUNTY: DuQuoin; population: 6,600. Need for additional physicians reported by secretary of county medical society. St. Louis, 75 miles. Several large industries. Any young physician could easily anticipate annual gross income in neighborhood of \$50,000-\$60,000. For detailed information contact: Ben A. Kinsman, M.D., James Stotlar, M.D., 15 Walnut, Pinckneyville.

Subsequent to the listings over the past 24 months, the following list of openings for associates in general practice is furnished. These pertain to downstate. Previous listings related to Cook County. This will be continued next month.

HENRY COUNTY: Geneseo; population: 6,000. Trade area: 12,000. Worling Young, M.D. in need of an associate. Prefers physician under 45 with some training in surgery. Opportunity for partnership after 1 year, if mutually satisfactory. Doctor has his own building; complete X-ray set up, cardiogram, lab, ultrasonic, etc. Six additional Drs. in community. One hundred bed hospital in town. Agricultural and industrial area. Eight Protestant and Catholic churches. Grade and high schools. Country club has 9 hole golf course. Municipal swim pool. Twenty miles from quad cities. Hospital recently enlarged. Contact Dr. Young at 944-3173.

JACKSON COUNTY: Murphysboro; population: 9,400. Trade area: 18,000. Opening for internist or GP to join six man group. Salary: \$25,000 first year. Opportunity for partnership after one year. No investment necessary. St. Joseph's Memorial Hospital; sixty-five beds. Industry and agriculture. Twenty churches. Grade and high schools. Six miles from Southern Illinois University. Local golf course. For details contact: W. J. Borgamiller, M.D., 215 N. 14th St., Murphysboro. Phone: 684-2172 or 684-4597.

KENDALL COUNTY: Plano; population: 6,000. Trade Area: 15,000. Plano Clinic in need of an associate due to large practice. Last associate moved to enter missionary field. Salary plus percentage. Opportunity for partnership after 6 months, if desired. Two physicians in community. Four miles to hospital at Sandwich, 64 beds. Diversified industry. Eight (Protestant and Catholic) churches. Four grade schools and high school. Aurora, 12 miles; population: 70,000. Active 9 hole golf course at edge of town. New shopping center. For details contact: R. F. Crawford, M.D., Plano Clinic, Plano. Phone: 312-552-3101.

LASALLE COUNTY: Ottawa. Trade Area: 40,000. Openings for GP and specialists at Ottawa Medical Center, S.C., established in 1946. Group now includes 3 generalists, 3 board surgeons, and part-time internist. Rapidly expanding industrial area. Salary open to negotiation. New 150 bed hospital, ground-breaking plan, March, 1970. Ninety miles southwest of Chicago, on I-80. Public and parochial grade and high schools. Four state parks within 15 miles. Contact: D. E. Moorhead, M.D., 313 W. Madison St., Ottawa. Phone: 815-433-1010.

LASALLE COUNTY: Seneca; population: 1,800. Trade area: 3,000. Office building built to serve two physicians. Physician could do his own surgery and obstetrics. One physician in community. New hospital at Ottawa, 15 miles, 114 beds. Sources of income: agriculture, explosives; factory and oil processing plant. Catholic and Protestant churches. Nearby country club. For further information contact: T. F. Mullen, M.D., Seneca.

Gastric Obstruction

From Gastrostomy Tube

By

RICHARD M. VAZQUEZ, M.D., MARSHALL GOLDIN, M.D., STEVEN G. ECONOMOU, M.D.,
CHICAGO

The use of a catheter gastrostomy for gastric decompression of selected patients during the immediate post-operative period obviates the necessity of a nasogastric tube and its undesirable features. Gastrostomy is also often employed to provide a route for alimentation when esophageal obstruction is present or for retrograde bouginage of esophageal stricture.

Method: To fulfill the above criteria we have modified, as have others, the standard Stamm gastrostomy to include the use of a Foley catheter, which is exteriorized through a counterincision.

Inflation of the balloon adjacent to the anterior wall of the stomach minimizes leakage of gastric content and prevents inadvertent removal of the catheter. The formation of a sinus tract facilitates the replacement of the gastrostomy tube if the new catheter is reinserted without delay. Use of a counterincision has reduced the incidence of wound infection.

Although the above method has been used with considerable success, a complica-

Requirements of a satisfactory gastrostomy include: 1) prevention of leakage of gastrointestinal content, 2) secure placement of the tube to prevent its inadvertent removal, 3) easy replacement of the catheter when it is temporarily removed, 4) provision for minimal possibility of wound complications.

tion peculiar to its use has been noted and forms the basis of this report. Recognition that the balloon of the Foley catheter could advance to the outlet of the stomach and cause obstruction has led us to suspect this condition and take proper measures to prevent its recurrence. The following case reports illustrate this problem.

Case No. 1 (M.S., PSL #849759)

This 51-year-old female with known intra-abdominal carcinoma developed a large bowel obstruction. At the conclusion of the celiotomy a Foley tube gastrostomy was performed for purposes of decompression. On the second post-operative day she began to



Richard M. Vazquez, M.D., (left), is a surgical intern at Presbyterian-St. Luke's Hospital. He received his M.D. from the University of Illinois. Marshall Goldin, M.D., (right) is a fellow in Thoracic and Cardiovascular Surgery at Presbyterian-St. Luke's Hospital. Steven G. Economou, M.D., (not pictured) is an attending surgeon at Presbyterian St. Luke's. This paper was supported in part by USPHS Grant No. 1 H12HE05808.



vomit. The gastrostomy tube functioned reasonably well but only intermittently. Accordingly, a nasogastric tube was inserted with decompression of the stomach and abatement of vomiting. On the fourth post-operative day bowel sounds were present, the gastrostomy tube functioned well, so the nasogastric tube was removed. The next morning she had copious green emesis which was refractory to antiemetic drug therapy. Drainage from the gastrostomy then increased from 450 ml. to 1850 ml. per day. Emesis continued and on the sixth post-operative day it was postulated that the balloon on the end of the Foley catheter which had been used as a gastrostomy tube might be obstructing the outlet of the stomach. Under fluoroscopic control, water-soluble contrast material (Hypaque®) was injected through the gastrostomy tube. The balloon at the end of the tube was demonstrated to be in the duodenum (Fig. 1). The balloon was deflated, the Foley catheter was retracted back into the stomach and the balloon reinflated. The patient rapidly improved and the nausea and vomiting did not reoccur.

Case No. 2 (H.R. PSL #814321)

This 73 year old male suffered hypoglossal nerve paresis and severe dysphagia after having a bilateral carotid endarterectomy. On the sixth post-operative day he suffered an acute myocardial infarction. He soon developed an aspiration pneumonitis. A Foley catheter was used to construct a feeding gastrostomy under local anesthesia. The patient tolerated the gastrostomy feedings well for three weeks but then noted a feeling of weakness and bloating after meals. An upper intestinal X-ray examination with Hypaque® revealed an esophageal stricture and that the balloon of the Foley catheter was in the duodenum. This was corrected by moving the catheter so that its tip lay in its proper position within the stomach. The patient again tolerated the tube feedings well but developed other unrelated complications. After a four month convalescence and readmission for an apparently successful esophageal dilatation, he was discharged with his health and nutritional status improved greatly.

Case No. 3 (G.G., PSL #769018)

This 52 year old female with a two year history of lymphocytic lymphoma was admitted for evaluation of hypersplenism and



Fig. 1. X-ray of the duodenum and gastric outlet showing the balloon (arrow) of the Foley catheter used to construct the gastrostomy lying within the duodenum and causing obstruction of the stomach.

the possibility of splenectomy. Up to the time of this admission her disease and its concomitant complications had been controlled with Chlorambucil® and Prednisone®.

The splenectomy was performed without incident, a gastrostomy was also constructed at this time. Two days post-operatively the patient complained of nausea; a nasogastric tube was inserted, a minimum amount of gastric drainage was obtained and the gastrostomy tube apparently functioned well. As her diet was increased, however, her post-prandial distress became more severe and in addition was aggravated by her assuming an erect position. An X-ray examination of the stomach with barium revealed the balloon tip of the catheter to be in the duodenum. The gastrostomy tube was removed and neither the post-prandial distress nor the nausea re-occurred.

Discussion

The case histories cited illustrate that partial or complete obstruction of the outlet of the stomach can be a significant complication when using the Foley catheter as a gastrostomy tube. It is recommended that after the catheter has been placed in the stomach that the serosa of the stomach be secured to the parietal peritoneum with multiple sutures of non-absorbable ma-

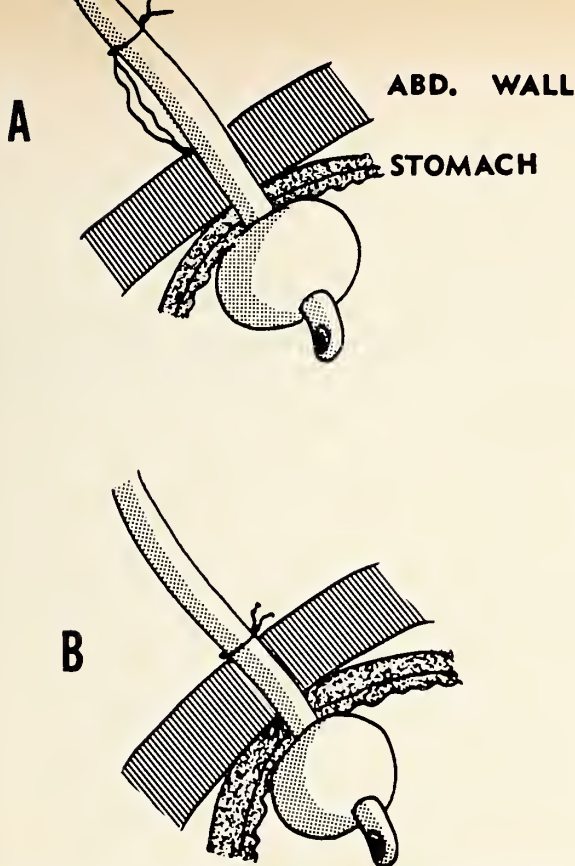


Fig. 2. A) This drawing demonstrates the incorrect method of anchoring the gastrostomy tube. B) This is the correct method of anchoring the gastrostomy tube. The ligature is flush with the skin allowing minimal mobility of the tube.

terial. Gentle traction should be placed on the tube so that the inflated balloon lies adjacent to the anterior wall of the stomach. The catheter must then be secured to the skin with a suture flush with the skin so that the catheter has a minimal mobility (Fig. 2).

The type of outlet obstruction described is more frequently observed in patients having a tube gastrostomy for a long period and in whom a sinus tract has formed. Under these circumstances, when a new catheter is reinserted it is frequently rather loosely taped to the skin, rather than being securely fixed with a silk suture. It thus has the opportunity to migrate.

Summary

The use of a Foley catheter for tube gastrostomy resulted in gastric outlet obstruction in three patients. Investigation of the cause revealed that the obstruction of the gastric outlet or duodenum was produced by the balloon of the Foley catheter. This can be prevented by anchoring the catheter flush with the skin with a stitch thus obviating migration of the Foley catheter.

Potassium in Dropsy

An \$8,000 grant has been made to Dr. Alexander P. Remenchik by Squibb Pharmaceutical Co. to study the metabolism of potassium by patients with congestive heart failure (dropsy). Dr. Remenchik is professor of medicine at the Loyola University Stritch School of Medicine.

Patients with dropsy (swelling induced by failure of the heart as a pump) are reported to have a potassium deficit. The deficit results in increased sensitivity to digitalis, one of the most important drugs in the treatment of the heart condition.

"It is important to know the extent of the deficit and whether there are simple ways of predicting it," Dr. Remenchik pointed out. "Presumably one could expect

some indication from blood samples, but previous work in this institution indicates that this is not the case."

Dr. Remenchik will also study the effect of a diuretic upon the potassium metabolism.

In his project he will have the use of a "whole-body counter", a device for detecting and measuring radiation. The clinician can measure directly the percentage of an oral test dose of radioactive material, in this case radioactive potassium, which is absorbed and retained by the body.

Collaborating with Dr. Remenchik are Drs. Ervin Kaplan, Donald T. Foxworthy and Jean E. Mossat.

Parking Will Get Even Worse

The Census Bureau estimates that by 1975 we will have 224 million Americans. The total could reach about 266 million by 1985, and about 325 million by 2000. The increase would be more than twice the population of Great Britain and five times that of Canada.

Fractures of

Fractures of the hand are not to be treated casually. Such injuries yearly account for the loss of thousands of working-man hours and millions of dollars. Serious disability and chronic discomfort are often the result of inadequate treatment for what is regarded as a minor fracture.

Movement in the hand requires the co-ordination of its musculature acting upon many joints to perform its delicate tasks. Because maximal function must be preserved, certain principles are to be observed in the treatment of fractures of the

hand. First, injured digits should be supported and protected, in flexion where possible, and, with rare exception, no finger but the injured one should be immobilized. Secondly, every uninjured member must be exercised actively, and passive stretching after healing should be avoided as it merely produces additional trauma with edema and increased pain, leading to greater stiffness and sometimes permanent disability. Finally, swelling should be controlled by elevation.

IRWIN M. SIEGEL, M.D./CHICAGO

Presented at the Thirteenth Annual Postgraduate Course in Trauma, The Chicago Committee on Trauma of the American College of Surgeons, April 16-19, 1969.

Fractures of the phalanges require accurate reduction as the finger mechanism is almost completely composed of connective tissues which are so functionally interdependent and delicate, that the mere superimposition of the normal fibrosis of repair may produce a substantial reduction in joint mobility. This fact is well illustrated by the simple finger joint sprain which, with or without treatment, is often prone to remain stiff, swollen and painful for months.

In treating such fractures, local block

anesthesia can be used with fast setting Gypsona type plaster. Keep in mind the remaining soft tissue hinge during reduction. Generally speaking, one should increase the deformity during the first phase of reduction. It is vital to get good X-rays when treating fractures of the fingers. The lateral X-ray is particularly important and, if necessary, dental film can be used between the fingers to obtain a good lateral film. Remember that the rate of healing differs at various levels in the finger.

The presence of a chip fracture usually

he Hand

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signifies a momentary subluxation of an interphalangeal joint, the chip representing ligamentous avulsion from the base of a phalanx (Fig. 1). Immobilization or traction for fractures of the fingers should be applied and aligned centering on the tubercle of the scaphoid rather than on the long axis of the metacarpal. This avoids rotatory deformity which can be quite disabling.

Fractures of the distal phalanx are very painful secondary to subungual hematoma (Fig. 2). This sometimes requires nail drilling for release of the hematoma. Incidentally, the nail should seldom be sacrificed as it serves as an excellent splint.

In almost all fractures of the hand in children, merely placing the hand in the proper position for retention splinting will

accomplish reduction, and there is considerable leeway when the angular deformity has its apex in the direction of flexion, that is, with the fragments hyperextended, at the time of healing. Exceptions are the three B's, Bennet's, Boxer's and Baseball type fractures which will be discussed in due course.

Finger tip injury may require split thickness grafting or even a pedicle skin graft, but expectant treatment with appropriate serial dressings allowing epithelization from adjacent skin is often remarkably successful.

Fractures of the middle phalanx are usually stable and simple to treat by splinting. Unstable fractures of this bone assume fairly consistent displacement patterns depending upon the location of the injury. Fractures of the proximal phalanx are usually angulated, apex anterior, and can be reduced with ease and immobilized in flexion. Light elastic traction may be necessary if the fracture is oblique (Fig. 3). Reduction and secure fixation is important. Malunion with residual angulation involves the flexor canal and its tendons in a mass of healing tissues, and produces a finger that is not only deformed but also stiff.

Dislocation of an interphalangeal joint (Fig. 4) results from hyperextension and is reduced by traction and flexion. When the base of the phalanx or condyle of the phalangeal head is fractured, coincident with dislocation, the reduction is unstable and surgery may be necessary. This operation should not be approached lightly as it may produce a stiff finger.

Dislocation at the metacarpal phalangeal joint (Fig. 5) is different from dislocation at an interphalangeal joint because its strong palmar ligament is incorporated into



Fig 1.

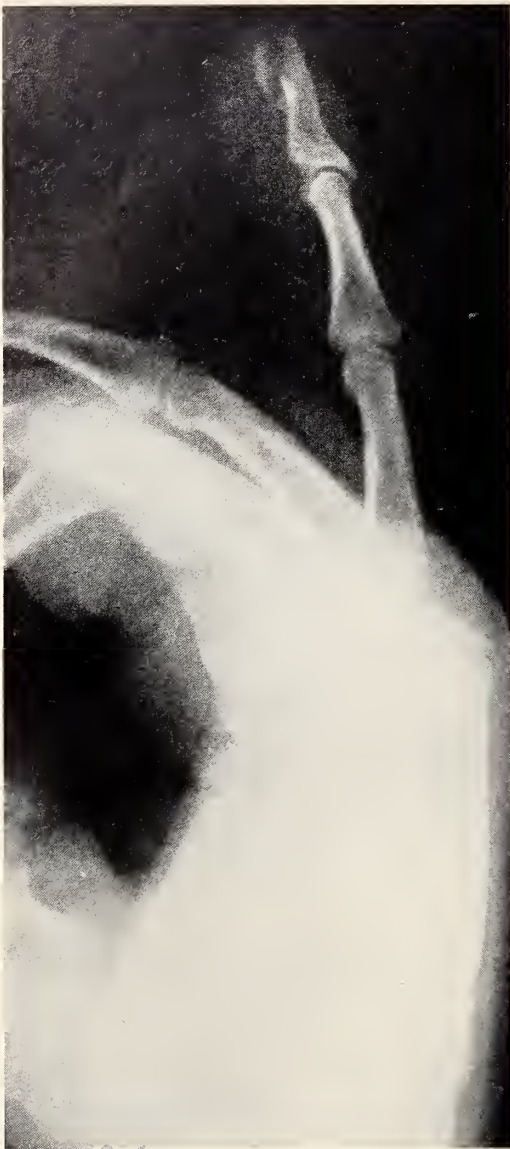


Fig. 2.

the volar capsule. Reduction is by hyperextension but traction will not help. A pushing reduction should be used. When the dislocation is locked by the palmar soft tissues, surgery may be necessary.

Complex dislocations are suspected when the long axes of the dislocated bones are parallel rather than at right angles. These dislocations often require open reduction. After reduction, fingers should never be splinted in complete extension on a tongue depressor or other straight splint. The p.i.p. and m.p. joints should be flexed, and plaster applied to the wrist, hand and finger. Occasionally, traction from a pin through the tough fibrous tissues of the distal end of the finger or through the bone of the phalanx distal to the fracture

may be necessary to maintain reduction. In epiphyseal separations or fractures, the possibility of growth arrest must be considered.

Fractures of the Metacarpals

The metacarpals are not straight but are slightly curved in their longitudinal axis. They are not all at the same level. There is a metacarpal arch, much like the transverse metatarsal arch of the foot.

Generally speaking, the lateral support and fixation of the muscles and fascial tissue minimize metacarpal displacement and control mobility of the fractured fragments so that malunion and nonunion are no more frequent than in fractures of the ribs which are similarly anchored. Thus, these fractures usually require only symptomatic treatment. If transverse, there is slight dorsal bowing (Fig. 6), and if spiral, there is some overlap, but reduction is usually unnecessary and thus splintage is superfluous. Disability is due only to limitation of finger movement from unnecessary and reprehensible prolonged immobilization of the knuckle joints. Nonunion is so rare that in any case where repair seems delayed, patience is all that is required.

The Boxer type fracture is a break at the neck of the metacarpal with angulation of the metacarpal head into the palm (Fig. 7). This requires reduction, and one should note that the lateral ligaments of the m.p. joint are taut in the flexed position and relaxed in the extended position. This is why the fingers can be abducted and rotated when they are in extension but

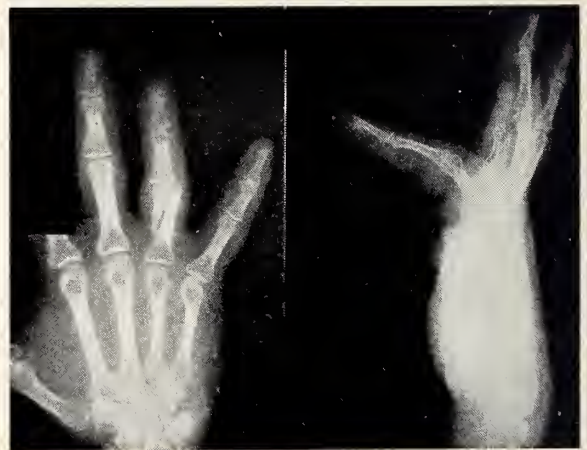


Fig. 3.

not when the m.p. joints are flexed to a right angle.

When the head of the relatively immobile third metacarpal is depressed, it becomes painful when grasping handled tools, such as a hammer, but a similar malunion in the other more mobile metacarpals seldom produces significant symptoms.

The fifth finger metacarpal is the one most frequently involved. Reduction is effected with the m.p. and i.p. joints at a right angle. One must watch for pressure of the finger tip in the palm and for pressure at the base of the nail. Excellent function usually follows this fracture.

Spiral fractures in metacarpals shorten slightly, but this creates neither functional nor cosmetic defect. Occasionally, an unstable metacarpal fracture producing a gross deformity should be treated by con-



Fig. 4.

tinuous traction until healed, but the penalty for this form of treatment may be prolonged finger stiffness. In selected cases, open reduction and internal fixation may be justified.



Fig. 5.

The Baseball Finger

A baseball (mallet) finger consists of a traumatic extension loss to the distal i.p. joint due to either (1) avulsion of the extensor tendon without bone, (2) avulsion of the extensor tendon with a chip of bone (Fig. 8), or (3) avulsion of the tendon in children with displacement of the epiphyses. The disability from this fracture is a 60 degree flexion deformity of the d.i.p. joint and hyperextension deformity of the p.i.p. joint because the lateral extensor slips retract and add their quota of power to the central slip in extending the p.i.p. joint.

For reduction it is obvious that the terminal joint must be held in hyperextension, but it is less well recognized that the proximal joint should be held in flexion in order to overcome retraction of the extensor tendon. Flexion of this joint puts



Fig. 6.

tension on the middle slip of the tendon and pulls it distally. Since the lateral slips are attached to the middle slip, they are also pulled distally, near to the bone from which they have been avulsed. To prove this, hold the proximal i.p. joint of one finger flexed to a right angle. Note that all the power of the extensor tendon over the terminal joint has disappeared. This joint is flaccid and powerless to extend because the lateral slips have been pulled distally and cannot retract and tighten. The correct position is held with a thin plaster, but one must remember that efficient splints are not easy to apply and are difficult to maintain, and few patients will tolerate an efficient splint for the time necessary to assure sound healing. Eventual fibrous union, attended by some weakness or loss in extension of the distal phalanx, is the rule. Fortunately, the consequent functional defect is usually unimportant. When required, surgery can be performed, but this almost always results in some stiffness of the d.i.p. joint. One must be careful not to injure the nail bed at the time of operation. It is best not to bury deep suture. A Bunnell-type pull-out wire is advised.

Fractures and Dislocations of the Thumb

Dislocation of the metacarpal phalangeal joint of the thumb is not uncommon (Fig. 9). Buttonholing of the thumb metacarpal may require open reduction. The technique for closed reduction is not by

traction but rather by flexing the i.p. joint, hyperextending the m.p. joint and pushing the base of the phalanx forward over the head of the metacarpal. Motion in the thumb m.p. joint after open reduction is sometimes quite limited, but this does not seem to be a handicapping disability.

Generally speaking, fractures of the thumb should be immobilized in abduction. If this is not done, the thumb has difficulty abducting after treatment.

A transverse fracture at the base of the first metacarpal has a deformity in flexion and adduction. Thus, it should be reduced in extension and abduction. If this angulation is left uncorrected, there is a slight loss of motion which, however, rarely inconveniences the patient.

Fractures of the shaft of the thumb which are comminuted or even open are encountered frequently because of the exposed position of this digit (Fig. 10). These fractures require at least six weeks of immobilization. One peculiarity of fractures of the phalanx of the thumb is that, for as long as six to nine months after clinical



Fig. 7.

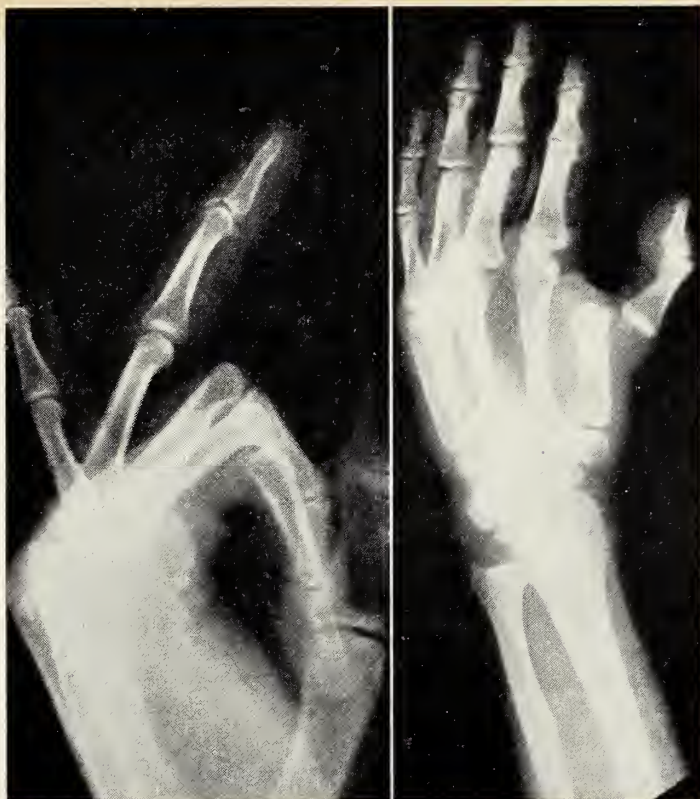


Fig. 8 & Fig. 9.

union, the X-ray may still show the fracture line.

The most complex thumb injury is the Bennet fracture which is really a fracture dislocation at the carpal metacarpal joint. A small fragment of bone remains behind in good articulation with the greater multangular and the remainder of the metacarpal dislocates. Standard position for immobilizing the thumb is so that it can touch the index finger. This is almost impossible to achieve without traction. One may use a small pin through the soft tissue at the end of the thumb or through the distal phalanx. This fracture usually occurs from a blow. The medial basal fragment remains in a normal position, but the metacarpal itself slides down the saddle-shaped surface of the greater multangular. Thus, after fixation there is often need for continuous traction or, alternatively, skeletal transfixion. Dislocation at the carpal metacarpal joint can often be reduced and held with plaster. With unstable fractures, casts can always be applied in two stages. First, up to the fracture site and then from this location over the fracture.

A Bennett's fracture can be treated by early motion, but one may thus encourage

the onset of osteoarthritis, requiring metacarpal carpal fusion, or metacarpectomy. The residual deformity, however, is seldom severe.

Summary

Fractures of the hand are not to be taken lightly or treated casually. Such injuries often produce permanent and severe disability. However, bearing in mind the principles of accurate reduction, adequate splintage, and the maintenance of maximal function, the management of these fractures should not prove troublesome. ◀

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Fig. 10.

NEW

PHARMACEUTICAL

SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

The following new drugs have been marketed.

NEW SINGLE CHEMICAL

LOCORTEN Corticoids-Local R
Manufacturer: CIBA

Nonproprietary Name: Flumethasone pivalate

Indications: Wide variety of dermatoses

Contraindications: Vaccinia and varicella. Hypersensitivity to any of the components.

Dosage: Rub cream into affected areas 3 or 4 times daily. Continue a few days after clearing of lesions.

Supplied: Cream—tubes of 5 and 15 gm.

DUPLICATE SINGLE PRODUCT

TENLAP Elixir Analgesic-Nonnarcotic R

Manufacturer: Dow

Nonproprietary Name: Acetaminophen (NF)

Indications: Analgesic-antipyretic for children.

Contraindications: Discontinue if sensitivity develops.

Dosage: Under 1 yr.: ½ tsp. 3 to 4 times daily

1-3 yrs.: ½ to 1 tsp. 3 to 4 times daily.

3-6 yrs.: 1 tsp. 3 to 4 times daily.

6-12 yrs. 2 tsp. 3 to 4 times daily.

Supplied: Liquid—125 mg./5 cc

COMBINATION PRODUCT

BSS: Eye Preparations R

Manufacturer: Alcon

Composition: Each cc contains:

Sodium Chloride 0.490%

Potassium Chloride 0.075%

Calcium Chloride 0.048%

Magnesium Chloride

Hexahydrate 0.030%

Sodium Acetate 0.390%

Sodium Citrate Dihydrate 0.170%

Indications: Physiologically balanced salt solution for irrigation of optic tissue.

Contraindications: None mentioned

Dosage: Treat intraocular tissue by attaching opthalmic irrigating needle. External irrigation may be done without needle.

Supplied: Drop-Tainer dispenser—15 cc.

NEW DOSAGE FORM

TENLAP: Antipyretic R

Manufacturer: Dow

Nonproprietary Name: Acetaminophen (NF)

Indications: Fever associated with childhood infections.

Contraindications: Sensitivity to acetaminophen or suppository base. Not recommended for children under 3.

Dosage: 3-6 yrs.: 125 mg. rectally 3 or 4 times daily.

Supplied: Suppositories—125 mg.

Axis Deviation in Bundle Branch Block

The histories of 117 patients with left axis deviation and complete right bundle branch block (RBBB) on the electrocardiogram were reviewed for evidence of clinical cardiac disease, hypertension or emphysema. One hundred fifty-four patients with complete right bundle branch block alone served as controls. The incidence of coronary artery disease (myocardial infarction or angina) was significantly greater in the group with pronounced left axis deviation; the other factors evaluated showed no significant difference between the two groups. Pronounced left axis deviation of the mean QRS axis is associated with a high prevalence of clinical coronary artery disease. The presence of complete right bundle branch block does not alter their relationship. Some patients with complete RBBB, or with RBBB and pronounced left axis deviation, have no clinical evidence of heart disease. (James B. McClenahan, M.D.: "The Significance of Pronounced Left Axis Deviation in the Presence of Right Bundle Branch Block." *California Med.* 110:5 [May] 1969.)

delegates handbook

illinois state medical society
may 17-20, 1970
sherman house, chicago

130th annual convention

INDEX

HOUSE OF DELEGATES

Agenda	372
Board of Trustees	369
Committees	374
Delegates and Alternates	370
Ex-Officio Members	369
Officers	369

OFFICERS AND ADMINISTRATION

President	376
President-Elect	376
First Vice-President	377
Second Vice-President	377
Trustee Reports	
First District	377
Second District	378
Third District	378
Fourth District	378
Fifth District	378
Sixth District	379
Seventh District	379
Eighth District	379
Ninth District	379
Tenth District	380
Eleventh District	380
Trustee-at-Large	380
Chairman of the Board	381
Executive Administrator	383
Speaker of the House of Delegates	384
Vice-Speaker	385
AMA Delegation	385
President of the Woman's Auxiliary	386
Committees of the Board of Trustees	
Advisory Committee to the Woman's Auxiliary	388
Committee on Committees	388
Committee on Constitution and Bylaws	388
The Educational & Scientific Foundation	389
Committee to Study Osteopathic Problems	389
Policy Committee	390
Publications Committee	390
Editorial Board	392
Editor <i>Illinois Medical Journal</i>	392
Committee on Usual & Customary Fees	393

ECONOMICS AND GOVERNMENTAL HEALTH PROGRAMS

Council on Economics and Governmental Health Programs	394
Committee on Prepayment Plans and Organizations ..	395
Medical Advisory Committee to IDPA	395
Sub-committee on Drugs and Therapeutics	395
Advisory Committee to the Division of Vocational Rehabilitation	396

EDUCATION AND MANPOWER

Council on Education and Manpower	399
Committee on Continuing Education	399
Committee on Scientific Assembly	400
Student Loan Fund Committee	400

Advisory Committee to Student American Medical Association	401
Committee on Allied Health Education	401

ENVIRONMENTAL AND COMMUNITY HEALTH

Council on Environmental and Community Health ..	402
Committee on Child Health	402
Committee on Maternal Welfare	403
Nutrition Committee	403
Committee on Public Safety	405

FINANCES AND BUDGETS

Secretary-Treasurer	408
Sub-committee on Benevolence	412

LEGISLATION AND PUBLIC AFFAIRS

Council on Legislation and Public Affairs	414
Eye Committee	415
Committee on Public Affairs	416
Task Force on Comprehensive Health Planning	416

MEDICAL-LEGAL

Medical-Legal Council	417
Committee on Impartial Medical Testimony	417
Committee on Laboratory Services	418
Committee on Licensure	418
Ethical Relations Committee	418

MENTAL HEALTH AND ADDICTION

Council on Mental Health and Addiction	419
Committee on Alcoholism	420
Committee on Narcotics and Hazardous Substances ..	420

PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Council on Public Relations	423
Committee on Insurance	424
Physicians Placement Service	425
Committee on Religion and Medicine	425
Task Force on Physician Shortage and Services to Medically Deprived Areas	426

SOCIAL AND MEDICAL SERVICES

Council on Social and Medical Services	427
Committee on Aging	427
Committee on Disaster Medical Care	428
Committee on Nursing	428
Advisory Committee to Paramedical Groups	428
Committee on Rehabilitation Services	429

SPECIAL REPORTS

Illinois Department of Public Aid	395
Illinois Department of Mental Health	421
Illinois Department of Public Health	405
Illinois Division of Vocational Rehabilitation	397

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EFEINGHAM	Peter C. Rumore	Delbert G. Huelskoetter	RICHLAND	Charles A. DeKovessey	Thomas Martin
FAYETTE	S. W. Moore	L. G. Oder	ROCK ISLAND	C. P. Cunningham	George H. Burke
FORD	Ross N. Hutchison	Edson L. Etherton		Theodore Grevas	John L. Eaton
FRANKLIN	John Pope	Harry Lewis	ST. CLAIR	William Walton	John Hipskind
FULTON	J. L. Gibbs	R. E. Reinertsen		Vivien P. Siegel	Dale Rosenberg
GALLATIN			SALINE-POPE-		
GREENE	James C. Reid	Jude A. Caselton	HARDIN	W. D. Tuttle	W. R. Durham
HANCOCK	Byron Mueller	C. W. Bruchsel	SANGAMON	Earl W. Donelan	Harvard L. Romence
HENDERSON	H. L. Bock	Civilino Lindo		Chauncy Maher, Jr.	Samuel J. Chapin
HENRY-STARK	Paul M. Schmidt	Lawrence N. Wathier		Edward G. Ference	Fenton G. Drake
IROQUOIS	R. Kent Swedlund	James E. Dailey	SCHUYLER	Henry C. Zingher	Russell H. Dohner
JACKSON	W. R. Malony	Dan B. Foley	SHELBY	Duncan Biddlecombe	Harvey H. Pettry
JASPER	Don Hartrich	Charles O. Absher	STEPHENSON	T. A. Haymond	E. L. Vickery
JEFFERSON-			TAZEWELL	Robert G. Rhoades	Arnold H. Claycomb
HAMILTON	Robert J. Dancey	Cyril J. Anslinger	UNION		
JERSEY-			VERMILION	T. E. Pollard	E. G. Andracki
CALHOUN	Bernard Baalman	Clyde Wieland	WABASH	T. R. Young	Ernest Lowenstein
JO DAVIESS	William G. Gilles	David Hockman	WARREN	Russell Jensen	Kenneth Ambrose
KANE	Robert G. Stone	A. Beaumont Johnson	WASHINGTON	J. L. Beguelin	Charles W. Longwell
	J. A. McDonald	Gerald J. Liesen	WAYNE	C. J. Jannings	D. A. Gershenson
	Wayne N. Leimbach	Peter Starrett	WHITE		
KANKAKEE	Dale M. Learned	David Hogg	WHITESIDE	John Hubbard	Clarence Mueller
KENDALL	W. H. Brill		WILL-GRUNDY	Robert J. Becker	John H. Kendall
KNOX	John J. Holland	Homer L. Fleisher		James H. Lambert	Guy A. Pandola
LAKE	John J. Ring	David S. Helberg		Barry S. Fong	F. Roger Fahrner
	Charles U. Culmer	John Andrews	WILLIAMSON	Herbert V. Fine	H. G. Diettrich
	Earl Klaren	Eugene Pitts	WINNEBAGO	H. E. Zenisek	E. T. Leonard
LA SALLE	Allan L. Goslin			Forrest H. Riordan III	Harry E. LaPlante
LAWRENCE	Tom Kirkwood	Gilbert Miller		F. A. Munsey	Robert D. Weber
LEE	Wm. A. McNichols, Sr.	Charles H. Lesage		R. E. Heerens	L. P. Johnson
LIVINGSTON	Don Ervin	Karl Deterding	WOODEORD	Victor Jay	Kazimieras Vaicius

CHICAGO MEDICAL SOCIETY

Delegates

Alternate Delegates

Delegates

Alternate Delegates

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William Ashley	Everett E. Nicholas
Charles J. Weigel	Michael J. Parenti
A. Everett Joslyn	Joseph B. Moles
Roland Kowal	Arthur G. Lawrence
Allison L. Burdick, Sr.	Gustav A. Henwall
Clair M. Carey	Craig D. Butler

CALUMET BRANCH

Eugene F. Diamond	Thaddeus C. Fial
Stanley E. Ruzich	Paul M. Blackburn
Robert E. Lee	Nestor S. Martinez

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L. S. Tichy	Arthur R. Fischer
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Raymond Nemecek	Miles Cermak

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Frank C. Kwinn	Joseph A. Patka
Frank J. Saletta	Kosme F. Kapov
William Nainis	John E. Meyer

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William J. FitzPatrick	Jerome T. Paul
John W. O'Donnell	George A. McDermott
Howard C. Burkhead	David W. Cromer
Harold C. Lueth	Willard A. Fry
C. Malcolm Rice, Jr.	John M. Bailey
John L. Savage	Arthur R. Crampton
James W. Ford	James R. Dillon

IRVING PARK SUBURBAN BRANCH

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Eugene Broccolo	Sanford Franzblau
Lawrence Hirsch	Kenneth J. Maier
Eugene Narsete	H. Paul Carstens
Allen Hrejsa	Alexander N. Ruggie
George C. Turner	Justin Fleischmann
Arthur T. Haebich	Frank J. Haufe
Thomas J. Conley	Philip H. Heller
Alfred J. Faber	Martin P. Meisenheimer

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William J. Hand	Chester C. Guy
David S. Fox	Henrietta Herbolsheimer
Loran H. Dill	Harry L. Hunter
Charles P. McCartney	Daniel J. Pachman
	Myron M. Hipkind

NORTH SHORE BRANCH

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Herschel Browns	Samuel T. Gerber
William G. Diffenbaugh	George C. Markoutsas
Joseph R. DeCaro	Rudolph W. Roesel
William O. Ackley	William B. Stromberg, Jr.
Frank M. Quinn	Frank Hyssey
John B. Murphy	Jack D. Clemis
David T. Petty	Steven J. Spinuzza
George H. Irwin	Rocco V. Lobraico
Burton J. Soboroff	Danforth Chamberlain
Clarence A. Norberg	Joseph H. Skom

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Jack Williams	Benjamin F. Lounsbury
Erwin M. Patlak	I. Pat Bronstein
Clifton L. Reeder	Joseph Schifano
James P. FitzGibbons	Lydia Nikurs
Michael H. Boley	Joseph C. Sherrick
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Samuel L. Andelman	C. Larkin Flanagan
William A. Hutchison	Bernard T. Peele
Coye C. Mason	V. Ray Silins

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Louis A. Wajay	Chester Podgorski
E. J. Kotanyi	N. J. Kupferberg
Michael J. Kutza	M. A. Rydelski

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Morris T. Friedell	Jere Friedheim
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Robert Van Etten	Herbert E. Fisher
Cyril Gallati	Gerard Gnade

STOCK YARDS BRANCH

Edwin J. Lukaszewski	Frank J. Nowak
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J. Robert Thompson	Louis S. Varzino

AT-LARGE

Francis W. Young
Ralph E. Dolkart
Fred A. Tworoger
Andrew J. Brislen
William E. Adams

Agenda

House of Delegates

1970

(The final agenda will be included in the packets distributed at the opening session of the House on Sunday, May 17, 1970)

MAURICE M. HOELTGEN, *Speaker*

PAUL W. SUNDERLAND, *Vice-Speaker*

FIRST SESSION

3:00 p.m., Sunday May 17, 1970
The Sherman House Chicago

1. Call to order by the Speaker
Maurice M. Hoeltgen, *Speaker*
2. Invocation
3. Roll call
Report of the Committee on Credentials
4. Report of the Committee on Rules and Order of Business
5. Approval of the minutes of the May, 1969 meeting of the House
(Abstracts enclosed in the packet for members of the House)
6. Remarks of the Speaker
Maurice M. Hoeltgen
7. Memorial service for members of ISMS who have died since May, 1969
Conducted by Jacob E. Reisch, *Secretary*
8. Introduction of representatives of the STUDENT AMERICAN MEDICAL ASSOCIATION
Reply by selected official representative
9. Remarks by the President of the Illinois Chapter MEDICAL ASSISTANTS ASSOCIATION
10. Report to the House of Delegates
Mrs. Sherman Arnold, *President*
WOMAN'S AUXILIARY, ISMS
11. Introduction of officers of other state medical societies and honored guests
Edward W. Cannady, *President*
(Introduction only, no remarks) .
12. Presentation of AMA-ERF checks to the representative of the five Illinois medical schools
Edward W. Cannady, *President*
13. IMPAC (Illinois Medical Political Action Committee) report
14. President's Address
Edward W. Cannady, *President, ISMS*
15. Report to the House
Roger N. White, *Executive Administrator*
16. Presentation of the EDWIN S. HAMILTON TEACHING AWARD of the Interstate Postgraduate Medical Association
17. Introduction of supplementary reports
18. Announcement of changes in Reference Committee personnel for 1970 House
Maurice M. Hoeltgen, *Speaker*
19. Introduction of resolutions and referral to correct reference committee by the Speaker
20. New business and announcements
21. Recess until 2 p.m. Tuesday, May 19, when the House will hear reports of reference committees

SECOND SESSION

2:00 p.m., Tuesday, May 19, 1970

The Sherman House, Chicago

1. Call to order by the Speaker
Maurice M. Hoeltgen, *Speaker*
2. Roll call
Report of the Committee on Credentials
3. Report of the Committee on Rules and Order of Business
4. Announcement of the recipients of the Scientific Exhibit Awards
J. Robert Thompson, *Director of Scientific Exhibits*
5. Introduction of officers of other state medical societies and honored guests
Edward W. Cannady, *President, ISMS*
(Introduction only)
6. Reports of Reference Committees
 - a. Constitution & Bylaws
 - b. Officers & Administration
 - c. Finances, Budgets and Publications
 - d. Legislation & Public Affairs
 - e. Education & Community Health Services
 - f. Economics & Social Services
 - g. Public Relations & Miscellaneous Business
7. Unfinished business
8. New business
9. Recess until 10 a.m., Wednesday, May 20, 1970

THIRD SESSION

10:00 a.m., Wednesday, May 20, 1970

The Sherman House, Chicago

1. Call to order by the Chairman
Maurice M. Hoeltgen, *Speaker*
 2. Roll call
Report of the Committee on Credentials
 3. Report of Committee on Rules & Order of Business
 4. Introduction of officers of other state medical societies and honored guests
Edward W. Cannady, *President, ISMS*
 5. Induction of J. Ernest Breed, *President-Elect*, into the office of President of the Illinois State Medical Society
OATH OF OFFICE:
(I, J. Ernest Breed, do solemnly swear that I will abide by the Principles of Medical Ethics of the American Medical Association and by the policies of this House of Delegates and that I will work toward the improvement of the practice of medicine and the care of the sick in Illinois).
Presentation of the President's Medallion to Dr. Breed
Edward W. Cannady, *Retiring President*
 6. Remarks of the *President*—J. Ernest Breed
 7. Presentation of the remaining reference committee reports
 8. Elections
Report of the nominating committee
 - a. President-Elect (Downstate)
 - b. First Vice-President (CMS)
 - c. Second Vice-President (Downstate)
 - d. Secretary-Treasurer (Downstate)
 - e. Speaker of the House (Downstate)
 - f. Vice-Speaker (CMS)
 - g. Trustees:

District	Terms expiring
3rd	William E. Adams
	James B. Hartney
4th	Paul P. Youngberg
5th	Darrell H. Trumpe
7th	Arthur F. Goodyear
8th	William H. Schowengardt
 - h. Delegates to the AMA (Take office 1/1/71 and to serve for two years to 12/31/72)
Terms expiring:
Maurice M. Hoeltgen
Leo P. A. Sweeney
H. Close Hesseltine
William K. Ford
Jacob E. Reisch
 - i. Alternate Delegates to the AMA (Take office 1/1/71 and to serve for two years to 12/31/72)
Terms expiring:
Theodore R. Van Dellen
Allison L. Burdick, Sr.
Arkell M. Vaughn
Paul A. Dailey
Jack Gibbs
 - j. Election of Delegate to serve the unexpired term of
Walter C. Bornemeier, resigned (now serving as *President-Elect* of the AMA)
To serve from 5/20/70 to 12/31/71
9. Unfinished business
10. New business
 - a. Fixing of the per capita assessment for 1971, based upon the recommendation of the Board of Trustees
 - b. Selection of the meeting place for 1973
 - c. Election of Emeritus, Retired members, and those whose dues have been cancelled for cause
Jacob E. Reisch, *Secretary-Treasurer*
 - d. Other new business
11. Adjournment, *sine die*

Committees for the 1970 House of Delegates

COMMITTEE ON CREDENTIALS

Andrew J. Brislen, *Co-Chairman*

L. T. Fruin, *Co-Chairman*

F. H. Riordan, III E. J. Lukaszewski

Eugene Johnson

This committee shall consider all questions regarding the registration and certification of delegates. The chairman or co-chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House on Sunday, and one-half hour prior to the opening of the other two sessions. (Tuesday and Wednesday).

The present schedule is:

Sunday, May 17	2:00 p.m.
Tuesday, May 19	1:30 p.m.
Wednesday, May 20	9:30 a.m.

TELLERS & SERGEANTS AT ARMS

Wayne N. Leimbach, *Chairman*

O. W. Pflasterer I. P. Lombardo

Paul M. Schmidt Erwin M. Patlak

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot vote is scheduled, or the House goes into executive session.

COMMITTEE ON RULES & ORDER OF BUSINESS

Robert R. Mustell, *Chairman*

John Hubbard Edward Krol

Myer Shulman John D. McCarthy

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the sessions of the House of Delegates. It shall work in close co-operation with the Speaker and the Vice-Speaker.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

The first meeting of the committee should be scheduled on Sunday morning, May 17, in order to have a report to present at the opening session of the House on Sunday afternoon as one of the first items on the agenda.

REFERENCE COMMITTEE ON AMENDMENTS TO THE CONSTITUTION & BYLAWS

7:30 p.m. Sunday, May 17 French Room 107

Glen E. Tomlinson, *Chairman*

C. P. Cunningham Charles J. Weigel

Don Erwin George W. Holmes

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution & Bylaws.

CONSTITUTION & BYLAWS COMMITTEE—Edward A. Razim, *Chairman*

REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND ADMINISTRATION

7:30 p.m. Sunday, May 17 Holiday Room 105

Charles U. Culmer, *Chairman*

Richard Schaele Eugene T. Hoban

Boyd McCracken Vincent Freda

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

THE PRESIDENT—Edward W. Cannady

THE PRESIDENT-ELECT—J. Ernest Breed

1ST VICE-PRESIDENT—Carl E. Clark

2ND VICE-PRESIDENT—George Shropshire

SECRETARY—Jacob E. Reisch

CHAIRMAN OF THE BOARD—Frank J. Jirka, Jr.,

TRUSTEES FROM THE ELEVEN TRUSTEE DISTRICTS

THE TRUSTEE-AT-LARGE—Philip G. Thomsen,

Immediate Past-President

SPEAKER OF THE HOUSE—Maurice M. Hoeltgen

VICE-SPEAKER OF THE HOUSE—Paul W. Sunderland

AMA DELEGATION—William K. Ford, *Chairman*

H. Close Hesseltine, *Secretary*

EXECUTIVE ADMINISTRATOR—Mr. Roger White

PRESIDENT, WOMAN'S AUXILIARY—Mrs. Sherman Arnold

ADVISORY COMMITTEE TO AUXILIARY—J. Ernest Breed

BOARD COMMITTEES:

Policy Committee—William E. Adams, *Chairman*

Committee on Committees—

Darrell H. Trumpe, *Chairman*

Committee to Study Osteopathic Problems—

William E. Adams, *Chairman*

REFERENCE COMMITTEE ON FINANCES, BUDGETS AND PUBLICATIONS

7:30 p.m. Sunday, May 17 Ruby Room 113

Francis W. Young, *Chairman*

Morgan Meyer Robert VanEtten

T. E. Pollard Casper Epsteen

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

ANNUAL AUDIT by Peat Marwick & Mitchell

THE TREASURER—Jacob E. Reisch

THE BENEVOLENCE COMMITTEE—Keith H. Frankhauser, *Chairman*

(A sub-committee of the Finance Committee of the Board of Trustees)

THE BUDGETS as prepared and presented for the information of the House

THE EDUCATIONAL & SCIENTIFIC FOUNDATION—Philip G. Thomsen, *Chairman*

THE ILLINOIS MEDICAL JOURNAL

THE PUBLICATIONS COMMITTEE—Jacob E. Reisch, *Chairman*

THE EDITORIAL BOARD—Harvey Kravitz, *Chairman*

THE EDITOR—Theodore R. VanDellen, *Editor*

REFERENCE COMMITTEE ON LEGISLATION & PUBLIC AFFAIRS

7:30 p.m. Sunday, May 17 Gold Room 114
Charles N. Salesman, *Chairman*
J. P. Campbell Alfred J. Faber
Ross Hutchison

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

COUNCIL ON LEGISLATION—V. P. Siegel, *Chairman*
PUBLIC AFFAIRS COMMITTEE—Theodore Grevas,
Chairman
EYE COMMITTEE—Frank J. Kresca, *Chairman*
MEDICAL-LEGAL COUNCIL—Noel G. Shaw, *Chairman*
COMMITTEE ON IMPARTIAL MEDICAL TESTIMONY—
Clinton L. Compere, *Chairman*
COMMITTEE ON LABORATORY SERVICES—
Grover L. Seitzinger, *Chairman*
COMMITTEE ON LICENSURE—William G. McCarthy,
Chairman
TASK FORCE, Comprehensive Health Planning—
V. P. Siegel, *Chairman*

REFERENCE COMMITTEE ON EDUCATION & COMMUNITY HEALTH SERVICES

7:30 p.m. Sunday, May 17 Crystal Room
William E. Adams, *Chairman*

Barry Seng Clair M. Rice, Jr.
J. H. Watts Robert E. Lee

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports

COUNCIL ON EDUCATION & MANPOWER—
Jack Gibbs, *Chairman*
COMMITTEE ON CONTINUING EDUCATION—
Herschel L. Browns, *Chairman*
COMMITTEE ON SCIENTIFIC ASSEMBLY—
Robert T. Fox, *Chairman*
COMMITTEE ON STUDENT LOAN FUND—
Donald Stehr, *Chairman*
ADVISORY COMMITTEE TO SAMA—
Norman Frank, *Chairman*
COUNCIL ON ENVIRONMENTAL & COMMUNITY HEALTH—
Edward A. Piszczek, *Chairman*
PUBLIC SAFETY COMMITTEE—
James P. Campbell, *Chairman*
CHILD HEALTH COMMITTEE—
Ralph H. Kunstadter, *Chairman*
MATERNAL WELFARE COMMITTEE—
Robert R. Hartman, *Chairman*
NUTRITION COMMITTEE—
Eugene F. Diamond, *Chairman*
Ad Hoc:
RADIATION—Howard C. Burkhead, *Chairman*
COUNCIL ON MENTAL HEALTH & ADDICTION—
Marshall A. Falk, *Chairman*
COMMITTEE ON ALCOHOLISM—
Abraham Gelperin, *Chairman*
COMMITTEE ON NARCOTICS—
Joseph H. Skom, *Chairman*
DIRECTOR: DEPARTMENT OF PUBLIC HEALTH—
Franklin D. Yoder
DIRECTOR: DEPARTMENT OF MENTAL HEALTH—
Mr. John F. Briggs, *Acting Director*

REFERENCE COMMITTEE ON ECONOMICS & SOCIAL SERVICES

7:30 p.m. Sunday, May 17 Old Chicago Room 101
R. K. Swedlund, *Chairman*

R. W. Jost Clarence Norberg
Robert Becker Clair M. Carey

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

COUNCIL ON ECONOMICS & GOVERNMENTAL HEALTH
PROGRAMS—Fred Z. White, *Chairman*
PREPAYMENT PLANS COMMITTEE—
Theodore Wachowski, *Chairman*
COUNCIL ON SOCIAL & MEDICAL SERVICES—
Thomas R. Harwood, *Chairman*
COMMITTEE ON AGING—
Thomas T. Tourlentes, *Chairman*
DISASTER MEDICAL CARE COMMITTEE—
Max Klinghoffer, *Chairman*
COMMITTEE ON NURSING—W. I. Taylor, *Chairman*
COMMITTEE ON REHABILITATION SERVICES—
Henry B. Betts, *Co-Chairman*
Joel Rosen, *Co-Chairman*
COMMITTEE ON PARAMEDICAL GROUPS—
Paul G. Theobald, *Chairman*
Ad Hoc: HOSPITAL RELATIONS—
Julian Buser, *Chairman*
COMMITTEE OF THE BOARD OF TRUSTEES:
USUAL & CUSTOMARY FEES—
Joseph R. O'Donnell, *Chairman*
DIRECTOR: ILLINOIS DEPARTMENT OF PUBLIC AID—
Mr. Harold O. Swank
DIRECTOR: ILLINOIS DEPARTMENT OF VOCATIONAL
REHABILITATION—Mr. Alfred Slicer
Advisory Committee to Illinois Department of
Vocational Rehabilitation—Eli Borkon, *Chairman*

REFERENCE COMMITTEE ON PUBLIC RELATIONS AND MISCELLANEOUS BUSINESS

7:30 p.m. Sunday, May 17 Time and Life 108
Fred A. Tworoger, *Chairman*

L. B. Hussey David T. Petty
C. J. Jannings, III Charles McCartney

This committee shall consider and submit its recommendations to the House of Delegates upon the reports of the following committees, and upon any other matters referred by the Speaker:

COUNCIL ON PUBLIC RELATIONS & MEMBERSHIP SERVICES—
Matthew B. Eisele, *Chairman*
PHYSICIANS PLACEMENT SERVICE
(Conducted by the Council)
COMMITTEE ON MEDICINE & RELIGION—
Anna A. Marcus, *Chairman*
COMMITTEE ON INSURANCE—
Paul A. VanPernis, *Chairman*
TASK FORCE, Physician Shortage & Services to Medically
Deprived Areas—Philip G. Thomsen, *Chairman*

Officers & Administration

PRESIDENT

The President of your Illinois State Medical Society has had a demanding but interesting and rewarding year. While ISMS faced many crucial issues in 1969-70, your Society vigorously asserted its leadership and met these challenges.

President's Tour—Highlighting this past year was the President's Tour, during which your President met with county medical society officers and delegates in all trustee districts. These meetings permitted a free exchange of ideas on the local level and gave your President the opportunity to address key community leaders and local news media through civic luncheons and news conferences. Vital issues discussed included rising health care costs, drug abuse and malpractice. The ISMS Auxiliary—as well as the IMAA—coordinated their programs with the President's Tour and we hope this will continue next year.

Rising Health Cost Campaign—To give ISMS' viewpoint on the recent controversy over rising health costs, your President made numerous speeches, appeared on television and wrote a six-part newspaper series that was published in the *Champaign Courier*, *Decatur Herald*, *Metro East Journal*, *Southern Illinoisan*, *Edwardsville Intelligencer* and the *Centralia Sentinel*.

On Nov. 23, your President appeared on Rock Island's station WHBF-TV where for 90 minutes we discussed the high cost of medical care. In both the newspaper series and the WHBF-TV appearance, we explained the many causes for the current health-care crisis and offered suggested solutions to curbing medical care costs.

Other Meetings—Your President met with Dr. George Miller of the University of Illinois, regarding ISMS participation in the university's proposed program on continuing medical education; attended an Illinois Nurses' Association banquet on Oct. 2; addressed the Chicago Medical Society on Nov. 11; the East St. Louis Rotary Club on Jan. 8; and the IMAA annual meeting in Peoria, April 17.

In addition, your President attended AMA's annual convention in July and the AMA Clinical Conference held in Denver in November, as well as all ISMS executive and Board of Trustees meetings, and the Leadership Conference on Feb. 8.

Summation—During this past year, your President has strived to implement the three points made in the Inaugural Address: 1) curbing the rapidly-increasing costs of medical care; 2) developing an independent council on

continuing medical education; and 3) establishing internship and residency programs in community hospitals. Despite the many attacks made on our system of health care delivery, progress toward improvement is being made in Illinois. For example, the internship and residency programs established in Rockford and Peoria by the University of Illinois should eventually attract more practicing physicians to Illinois.

Your President has utilized every possible method for carrying the ISMS program to our membership and to all Illinois citizens. It is hoped that these efforts have firmly established the State Society as a leader in providing the best possible health care for the people in Illinois. Your President extends appreciation to Mr. Roger White, our Executive Administrator, and to the entire ISMS staff for their invaluable assistance during the year.

Edward W. Cannady

PRESIDENT-ELECT

Serving as President-Elect during this past year has been a most pleasant and instructive experience. It has been a privilege to observe the confident efficiency of our President, Doctor Edward Cannady. He has served as an inspiration for me and at the same time has made me realize that he will be very difficult to follow.

I represented our Society at the Michigan State meeting on September 29-30 and at the Indiana State meeting on October 14-16. Both were very pleasant and instructive experiences. The problems faced by the Michigan House of Delegates and also by the Indiana House are similar to our own. It was encouraging to see the dedication of the delegates, particularly in Michigan. At both meetings my reception was quite cordial and I enjoyed them very much.

In October and again in January I met with representatives of the Chicago Dental Society, the Chicago Medical Society, the International College of Surgeons and several other medical groups. The meetings were called by the Chicago Dental Society to investigate the possibility of joining together in a condominium type office building which would be located somewhere north of the Chicago River, south of Chicago Avenue and east of Michigan Avenue. If and when the specific plans are promulgated they will be presented to the Society.

I attended the AMA Convention in New York on July 13-18, as well as the Convention held in Denver on November 29-December 3.

On February 8, I attended the ISMS Leadership Conference held at the Sheraton Blackstone Hotel. The significance of malpractice insurance and peer review which were emphasized is such that a major effort will be made during the coming year to alert the membership in these areas.

On February 20, I attended the Comprehensive Health Planning all-day meeting held in the Sheraton Blackstone Hotel. And on February 27-March 1, I attended the ISMS and AMA Public Affairs meetings in Washington.

I also attended the Fourth Annual Congress on Socio-Economics sponsored by the AMA on March 20-21, at the Palmer House in Chicago. It is obvious that this section of medicine is becoming more and more significant.

On May 2, I spoke before the Wisconsin Physician-Clergy Conference held under the direction of the Wisconsin State Medical Society and the United Methodist Church. The title of the paper was "Medical and Pastoral Care of the Terminal Patient."

The President-Elect serves as the Chairman of the Advisory Committee to the Woman's Auxiliary. A meeting was called on January 18, and a report on this meeting will be found listed under this committee.

I wish to thank the members of the Board and the officers for their cooperation throughout the entire year.

J. Ernest Breed

FIRST VICE-PRESIDENT

Previous reports to the House of Delegates by the Vice-Presidents have pointed out the lack of assigned responsibilities to these offices.

During the year 1969-1970, it was evident that this officer could assist the President in his many arduous duties. The representation of the ISMS at many meetings in neighboring state societies was one necessary duty. It has been my pleasure to represent President Cannady and the Society at the annual meetings of Kentucky, Wisconsin and Iowa. These visits are more than courtesy calls, and provide an opportunity to become acquainted with our professional neighbors, and to observe their officers and House of Delegates in action.

In this way, we become aware of their activities and problems as well as being able to inform them of what Illinois is experiencing in a mutual field of interest and concern.

The hospitality in each instance was very gracious and reminds us that we should reciprocate in turn.

Carl E. Clark

SECOND VICE-PRESIDENT

During the past year it has been my privilege to observe and participate in the deliberations of the Board of Trustees of the ISMS, and I have been impressed by the dedication and commitment of its members, addressing themselves to the problems they face in this new decade. As consultant to the Task Force on Physician Shortage and Services to Medically Deprived Areas, the Committee on Usual and Customary Fees and the Council on Economics and Governmental Health Programs, I actively participated in their proceedings, which enabled me to further understand the problems which organized medicine must face. There are, however, some still unanswered questions.

While the Task Force on Physician Shortage and Services to Medically Deprived Areas met only once, to my knowledge, its proposed plans for action are important first steps toward the solutions of these urgent problems. Inasmuch as these efforts are mainly directed to the alleviation of the physician shortage among minority groups, the

ISMS should also address itself to the correction of the poor quality of education in our public schools. The high school and college level preparation of many Negro students is weak in the areas of bioscience, mathematics and English, which acts as a handicap for gaining admission and success in medical school. Indeed, the outlook for increasing the number of Negro physicians is not encouraging unless we can have an impact on the educational system down to the elementary level. The recently reported results of the nation-wide achievement scores, revealing the poor scores for the Chicago Public Schools, further emphasizes this need.

Another cause for concern is the expansion of governmental health activities and controls, and increasing outside regulation of physicians' fees. Perhaps, we should begin by taking stock. In part, this regulation of doctors' fees is related to our failure to make the public aware that the increased cost of "medical" care is related more to the accelerating upward spiraling costs of hospital care during the past twenty-five years, which if plotted as a graph would run off the page. Then too, there seems to be a lack of awareness, and certainly a lack of indignation of these encroachments by outside agencies.

Indeed, organized medicine assumes a defensive attitude in response to the abuses perpetrated by a handful of unscrupulous physicians guilty of exploitation of public aid recipients. To be sure, "Peer Review" is a necessary approach to overhauling a machinery which allows such exploitation. Yet our publicity points out that this overhauling is "geared to curb wasteful practices among doctors," instead of emphasizing that it is directed to curb the "mass production specialist." We can ill afford such publicity which indicts the medical profession as a whole.

Insurance carriers and governmental agencies base their regulation of physicians' fees on a "profile," which they have established for participating physicians. These "profiles" are available only to these agencies, not to organized medicine. The fees paid physicians may be frozen at any point, making no allowance for the cost of living index or inflation. And our leaders accept this, making it easy for these agencies to act arbitrarily in these matters.

Perhaps, more portentous is the collusion between unions and insurance carriers in determining the "usual, customary and reasonable fees" to be paid physicians. In any bargaining between labor and management in which the physicians' fee is a part of the agreement, organized medicine should have a set of guidelines based on what is considered fair and equitable, and should insist upon participation in such discussions. Certainly, no union would permit physicians to determine the wage scale of its members. If organized medicine presently has representatives at these discussions, they must be replaced by more concerned and sophisticated physicians before we become victimized by doing too little too late.

George Shropshire

SECRETARY-TREASURER

The report of the Secretary-Treasurer will be found under Finances and Budgets, page 408.

TRUSTEES

FIRST DISTRICT

A real surge of awareness is apparent in the activities of county medical societies in the First District. Comprehensive Health Care, Medicare, Medicaid, Malpractice. These topics, and more, have been covered in meetings throughout the year.

Delegate attendance and participation was very good at the 1969 Annual Meeting.

The meeting of the county societies officers and delegates with the President at the time of his Tour came to a focus on many subjects related to the social and economic aspects of medical practice.

Geographically, the First District is as wide as the state of Illinois. It is understandable that the needs and concerns of counties adjacent to Chicago may, and do, vary from those counties bordering on the Mississippi River. It is in this context that the Trustee and the ISMS staff can be of assistance. Closer contact has been sought so that the views of all counties are heard at the state level.

Joseph L. Bordenave

SECOND DISTRICT

The Second District has been in a rather static position, with a steady loss of doctors in the region as a whole. The various counties have been active in their meetings with the exception of Lee County and this area is now showing more active interest in the Society. The highlight of the past year was the President's Tour meeting in LaSalle-Peru. We are hopeful that such will become annual affairs for they are stimulating meetings.

Whiteside County was pleased with the student externs last summer; other hospitals in the area are working toward such programs.

William A. McNichols, Jr.

TRUSTEES OF THE THIRD DISTRICT

1. Branch meetings attended and reporting on actions passed by the House of Delegates and problems discussed by the Board of Trustees of ISMS
2. Representation of ISMS at the Annual Meeting, at Midwest Regional Health Science Library and Cooperative Information Services

At the third annual meeting of the Council held October 17, 1969, at the John Crerar Library, future plans of the library were discussed and suggestions made for improving services available. It was reported that progress was being made in the preparation of a union list catalog. It was also reported that participating Council members and representatives have now reached a total of 96.

In order to expedite its activities and to permit more rapid advance, minor changes in the bylaws were suggested and approved. Final actions of the Council were to approve a nominating committee report for the slate of officers for 1969-70 consisting of:

Mary Jane Laatz, *Chairman*

Glenn Brudvig, *Vice-Chairman*

Mrs. Elizabeth Frederick, *Recording Secretary*

Executive Committee

Louise C. Lage

Earl Graham

Robert Cryder

Other activities were concerned with the Council of the Chicago Medical Society and may not appropriately be included in this report.

William E. Adams

FOURTH DISTRICT

The constituent medical societies of the Fourth District have functioned without any serious mishaps throughout the past year and the activities of any single county can

well apply to the group as a whole.

At the present time probably the most important and top priority measure is that of Peer Review. Several counties have made major strides in Peer Review through its Insurance, Grievance and Ethical Relations committees.

Rock Island County, in January, approved the appointment of a committee to work with the Scott County (Iowa) Society with the result that an Executive Secretary and office was agreed upon. At the present time this is functioning satisfactorily.

Throughout the district the Public Health committees have provided the leadership for rubella immunization clinics. With the cooperation of the Illinois Department of Public Health and school officials, a high percentage of eligible children were immunized.

With the Division of Services for Crippled Children, monthly orthopedic clinics have been established.

In several counties, chapters of the Medical Assistants Association have been established with advisory committees to assist the chapters.

The District has worked closely with the news media. In recent months doctors were provided for television programs on drug abuse and alcoholism. We had the pleasure of having our ISMS President appear in various counties of the District on television programs concerned with rising costs of health care.

Society members have actively provided the news media a series of articles on the physician shortage.

One of our counties initiated two resolutions now under consideration at the state level concerning licensure by reciprocity.

Society members have been active in the program for health care of migrant workers and have received laudatory letters from the Migrant Workers Council.

I extend my gratitude to the officers of the various component societies and to the staff of ISMS for their kind assistance during the past year.

P. P. Youngberg

FIFTH DISTRICT

A Fifth District meeting of the Delegates and Alternate Delegates, county presidents and officers was held March 12, in Springfield. This was in conjunction with the annual "Work Shop" and President's Tour. This was well attended and received.

The eight component societies continue to function smoothly, the larger ones meeting regularly, the smaller only as needed.

During the past year no problem has arisen requiring consideration by the three District committees. This next year will most likely see some of the responsibilities and purposes of the committees combined into a District Peer Review Committee.

Three (Tazewell, Sangamon, and McLean) of the component societies have now employed part time Executive-Secretaries. These men are taking a most gratifying interest in our socio-economic, legislative and educational problems.

Sangamon County Medical Society, Memorial Hospital of Springfield, St. John's Hospital and Southern Illinois University have done more than just talk about the shortage of physicians, and especially those willing to work in the more rural communities. Southern Illinois University Medical School in Springfield is becoming a reality. A Dean has been appointed—Dr. Richard H. Moy of the University of Chicago—who has opened a University office and is busily

engaged with local advisory and search committees in establishing a teaching staff.

A number of members of the Fifth District continue to be active on the various ISMS councils and committees, many times at great sacrifice of time from work and home. The scheduling of the next committee meeting should be a part of the minutes of the meeting as far as feasible. Likewise, the chairmen should remember that the same highways and modes of transportation lead to other Illinois centers as well as into Chicago. In fact, any airport is easier to use than O'Hare Field, and the Dan Ryan Expressway is impossible at 5 p.m. I am eternally grateful to these men serving on committees—for their willingness to serve and their dedication to ISMS. Our society owes these men a vote of gratitude. May I suggest a certificate of commendation be sent to each and every council and committee member by the President and Chairman of the Board of Trustees as soon as feasible after each annual meeting.

Your Trustee wishes to express his appreciation for the warm hospitality and cooperation of the members of the constituent societies and their executive secretaries, and last but not least Mr. Roger White and the dedicated members of his staff in Chicago and Springfield.

Darrell H. Trumpe

SIXTH DISTRICT

A District meeting was held in Quincy on October 16, 1969 in conjunction with the President's Tour. President Cannady addressed the meeting as did Illinois' newly appointed U.S. Senator Ralph Tyler Smith. Another District meeting will be held in Chicago on Sunday, May 17, 1970 to consider current problems in the Sixth District and to discuss matters coming up for consideration before the 1970 meeting of the House of Delegates.

No problems arose in the Sixth District during the past year which required the attention of the Ethical Relations, Grievance, or Prepayment Plans and Organizations Committees.

An increasing awareness of the importance of political involvement by physicians seems to be occurring in our part of the state; this is most important if the viewpoints of the individual physician and of organized medicine are to be given proper consideration at every political level. Physician support was strong at the very successful Downstate victory dinner for Sen. Smith, held at Belleville, on March 5, 1970.

In the Sixth District, insurance carriers (through third party contracts negotiated by management and labor involving health care) and governmental agencies at the local, state and national level continue at an increased pace to attempt to impose fixed fees upon the physician. Concerted action by groups of physicians at the county, district, state and national levels offer the best chance for negotiating these problems. Hopefully, the Peer Review mechanism will give the individual physician the opportunity to seek redress in these matters involving the host of third party agents.

I have attended most of the meetings of the Board of Trustees and of the Finance Committee and the Committee on Usual and Customary Fees, as well as several Ad Hoc Board Committees during the past year. The cooperation and assistance of Mr. Roger White and members of his competent staffs in both the Headquarters Office in Chicago and in the Springfield office have greatly aided me in performing my duties in the Sixth District during the past year.

Mather Pfeifferberger

SEVENTH DISTRICT

Physician shortage has become a predominant issue in the Seventh District.

A Physician's Recruitment Committee has been created in the Macon County Medical Society, recognizing that "Physicians must recruit Physicians." Support and cooperation in this venture is being given by the Chamber of Commerce and Jaycees.

Emergency room service by group employed local physicians has been established in both major Decatur hospitals, under approval of each hospital staff. Hospital administrators are cooperating fully. Excellent and immediate emergency care is made available twenty-four hours a day.

Comprehensive Health Planning remains under medical leadership in this area. A \$6,000.00 grant has been obtained. A pre-planning stage is now in progress.

A "Continued Medical Education" program has been established by the St. Mary's Hospital and Decatur Memorial Hospital staffs jointly. Monthly meetings, one hour at noon, are held alternately at the hospitals. Attendance has been nearly 100% and with enthusiastic reception.

The District committees on Ethical Relations, Grievance and Prepayment Plans were not called upon for problems.

A canvass of the component societies affirms concerned active interest in socio-economic, leadership, continued medical education and community service programs.

The Woman's Auxillary tirelessly gives to their activities for which your Trustee gives his profound thanks.

Dr. V. T. Turley and "Your Trustee" were presented with Fifty-Year Club Awards on May 27, 1969, at the Macon County Medical Society Meeting, held at the Decatur Club in Decatur.

"Comment"—Fifty years doesn't seem very long.

In summary, the constituent societies of the Seventh District have shown progress and accomplishment in the fields of physician shortage, comprehensive health planning, continued medical education and hospital emergency services.

Your Trustee continues to express appreciation to the component societies and auxiliaries for their cooperation and support.

Arthur F. Goodyear

EIGHTH DISTRICT

No report.

NINTH DISTRICT

As trustee of the Ninth District of the Illinois State Medical Society, I have tried during the past year to officially carry out the duties of this office. No invitations, however, have been extended to me by any medical society in the Ninth District other than my local medical society. At various times I have contacted members of some of the medical societies within my District, including the delegates, and they are rather non-responsive to attend meetings held by the State Medical Society for the benefit of the members of the State Medical Society.

The District Ethical Relations Committee had no meeting during the year. The District Grievance Committee, however, did have one meeting to settle a dispute between a physician and one of his patient's relatives. This was settled with no one having any complaints after the settlement. The Prepayment Plans and Organization Committee had no meetings during the past year.

A combined District meeting of the members of the Ninth and Tenth Districts was held at Augustine's Restaurant in Belleville the first Thursday after the first Tuesday in November. This was well attended, especially the scientific programs. However, that portion of the program which related to medical society functions was very poorly attended.

I have attended all but one of the Trustee meetings during the past year. This meeting could not be attended because of bad weather and lack of plane flights.

The staff of the ISMS has been very helpful in sending out various notices to members of the Ninth District, keeping them well informed on various matters pertaining to the State Medical Society's function.

I wish to commend the staff members of the ISMS for their help.

Charles K. Wells

TENTH DISTRICT

May 1969-February 1970

Categories of activities and meetings attended:

- 1) County Societies
 - 2) AMA—Clinical and Annual
 - 3) Regional Medical Program (Bi-State)
 - 4) Comprehensive Health Program (Bi-State—ARCH)
 - 5) Belleville Area College—Dept. of Nursing
 - 6) Leadership Conference, Chicago
 - 7) Nurse Scholarship Association of St. Clair County
 - 8) Health Guide Program
 - 9) AMA Committee on Health Care for the Poor
 - 10) Public Affairs, Washington, D.C.
- 44 meetings; plus all meetings of ISMS Board of Trustees

Dominant thoughts physician members are concerned with:

- 1) Medical liability (malpractice) problems.
- 2) Physician shortage and distribution.
- 3) Third party economic relationships.
- 4) Misrepresentation of the profession before the public by some news media.
- 5) Personal involvement with continuing education.
- 6) Adverse effect of civil-social discord on delivery of health care; improved in St. Clair County but distressing in Alexandria County.

Physicians and their wives throughout the district have provided leadership and participation in nurse scholarship activities, hospital expansion, home centered health care, community health programs including health care of the poor, constructive political action and legislative education.

An ongoing assessment of our priorities and their execution is both laudable and necessary to properly serve the needs of our members and assist in fulfillment of their professional and civic roles.

The District appreciates reflections of achievements of our distinguished member, President Edward W. Cannady.

Grateful acknowledgment to the county societies' members, delegates, officers and wives for their warm and friendly hospitality and to the staff of ISMS for expediting the transactions and activities of our District.

W. C. Scrivner

ELEVENTH DISTRICT

The many problems and decisions confronting medicine are well known to all constituent members of the ISMS.

Your Trustee has attempted to represent you in a manner which would go along with your individual vote.

The Board of Trustees continues to be a proving ground for representation; however, on occasion it is most difficult to get the many complicated issues brought back to the individual county medical societies as a complete summation. I trust that the minutes of the Board actions have proven of benefit in keeping you informed.

The recent symposium in "Malpractice and Peer Review" probably represents the most pressing issues of the year. Your comments and recommendations are most sincerely invited.

As a Trustee, I attended all the Board meetings as well as committee meetings to which I was assigned. I also served as Chairman of the Usual and Customary Fee Committee, and request your reading this committee's report in detail.

I again wish to encourage widespread local participation in County Medical Society activities by all the membership. In no other way can you better maintain a voice in organized medicine.

Joseph R. O'Donnell

TRUSTEE AT LARGE

"Old Presidents never die; they just fade away," as a paraphrase of an old saw might go. Hopefully, however, I have not quite done that. My year as President having been completed, there were many opportunities to look back, reminiscence, and to see where I could have said and done things differently. This has been a constant spur to keep me continuing to work for the betterment of the profession and the improvement of health care in Illinois. I hope my contributions to the Board, and my role as immediate Past President, have helped in these regards.

During the past year, many courtesies have been extended to me by the Board, by the officers, and by the staff. For these, I am grateful. In addition, I have been privileged to serve on several special committees, and to chair the task force on physician shortage and medically deprived areas. I shall continue to work to the best of my ability in all of these areas in the future.

My years on the Board and as an officer have been some of the most memorable and pleasurable of my life. I have had the opportunity to meet many thousands of people and to exchange viewpoints and share concerns with them. The ideals and energy of our Illinois physicians never cease to amaze me, and I will do all in my power to continue to present the concerns of these warm, dedicated persons. They have given me inspiration and edification. I leave the Board reluctantly and as I leave, I want to extend the challenge to those carrying on, to meet those forces which would destroy our system of medical care; those who would emasculate our profession; those who would substitute something less than we have, to pick up the gauntlet and join the fray. We must continue to strive to provide a united front, in the betterment of the health and well-being of the citizens of Illinois.

The staff of the ISMS, in my estimation, is remarkable. During all of my years of service, they have never ceased to be ready, willing and able, to help me whenever I needed help and asked them. My sincere thanks to Mr. Roger White, to the Division Directors, and to all of the members of the staff.

Philip G. Thomsen

CHAIRMAN OF THE BOARD OF TRUSTEES

During the past year the Board of Trustees has been faced with many concerns in the betterment of health care in Illinois. Likewise, the affairs and operation of the ISMS present unique opportunities to improve the role of the physician and provide concerted efforts and action. The Board has functioned harmoniously and objectively. I extend my sincere gratitude to all the Board members for the assistance and consideration they have shown in ensuring a smooth flow of work.

Many items presented to the Board originate with the several Councils and Committees. To avoid duplication, my report as Chairman of the Board will concern itself only with those items not pertaining to any action instituted through a Council or Committee and which would be reported elsewhere. In acting upon the specific recommendations, the unanimity of the Board attests to the excellent spade-work performed by all those charged with specific responsibilities.

Utilization Review—Peer Review

During the past year, many questions on Utilization Review were presented. The Department of Public Health and the Department of Public Aid asked that ISMS provide physicians to act as paid consultants to review nursing home patients, since they are under Medicaid. Continental Casualty Company also asked for review of utilization of ambulatory out-patient services rendered by physicians under Part B. Blue Shield requested that a consultant in each District be named to aid in utilization review.

These many concerns were pondered and probed in depth. Several solutions were suggested but no one program was found completely satisfactory, until early in 1970. At that time a complete peer review system was presented, having been under development for several months, which would incorporate the activities of District Prepayment Plans and Organizations and Grievance committees. The peer review mechanism would also function in utilization review from the physician standpoint and would cooperate with hospital utilization review committees. The guidelines received wide dissemination and all county medical societies were encouraged to establish such a mechanism, which would also serve as a bridge between medical societies and third-party carriers.

Peer review will allow scrutinization of medical costs and the utilization of services. This in turn will allow quicker response to problems and needs. However, this will also require the cooperation of carriers in reviewing records and the interchange of materials. Peer review is a two-way street. We must be prepared to look into every facet of care so we can recommend remedial actions or direct criticism against the actual offender when questions arise.

While it is too early to evaluate the application or effectiveness of this new system, I feel certain it will resolve many of the problems surfacing in this area of concern. It is also evidence of a means by which all Illinois physicians are served by ISMS. A detailed report of the suggested guidelines appeared in the March *Illinois Medical Journal* and further information may be obtained from the Council on Economics and Governmental Health Programs.

Structure of Councils and Committees

Of particular personal satisfaction was the much

smoother functioning of the Council and Committee structure. We have struggled for several years in an attempt to get things dovetailed and specific responsibilities and activities spelled out. I feel this has come closer to being accomplished, due to long hours spent by several Board committees and staff.

Originally a reporting mechanism, our councils have now begun to function as generators, not only for activities of committees, but for themselves as well; this made the work of the Board much more facile. Each council, as it reported and recommended to the Board, had the complete background of its proposal and gave excellent presentations.

In addition, a realignment placing task forces directly under the Board, as well as some special Board Committees composed of non-Board members, made the chain-of-command much easier to understand and allowed each committee to see its exact sphere of operation. In addition, provision of ad hoc committees, as needed, for each council, gave the councils the ability to address specific concerns. To allow for this, a man-power pool of members will be maintained to be called upon as needed. Appointment of SAMA members to the various councils and committees resulted in significant beneficial involvement of many students.

While this concept will continue to go through a shake-down to eliminate duplications and further refine our operations, I feel tremendous strides have been made in streamlining our operation. We have built-in flexibility, with sufficient control and direction to maintain an operation which will serve all needs of the membership.

Membership Opinion Survey

A second survey of the membership's opinions on important issues was authorized by the Board. While not a sequel to the 1968 survey, the 1969 survey, funded by the *IMJ* Publications Improvement Grant, delved much deeper into very specific questions. The results were amazing; 38% of the members responded. This surpassed 1968 by several per cent and indicated that the members are willing to pull together in concerted actions. A further extension sent the 1969 survey to residents, interns, and students in Illinois. This provided a means to survey the similarities between these groups and the practicing physician. Very promising, reassuring results were obtained. A series of four *Journal* articles reported the outcome.

The enthusiastic response to these surveys is most appreciated by me and by the entire Board. Answers provide further insight into activities which ISMS should be following, and referral of items for action to appropriate councils will result in improved services to the membership. The policies derived will most certainly reflect Illinois medicine's stance and needs.

Medical Education

While the Council on Education and Manpower undoubtedly will report on several activities in education programs, I would like to touch briefly on a couple of items. We have enjoyed excellent rapport with the medical schools, particularly the deans, and have addressed ourselves to some very important mutual activities.

ISMS fully supported a bill passed by the Illinois legislature granting \$6.1 million to the Chicago Medical School to enlarge facilities and increase enrollment. Likewise, we have supported additional legislation to grant funds to private medical schools to expand programs. In addition, retention of personnel trained in Illinois became a topic

of prime importance, as well as increased production of physicians. Our Task Force on Physician Shortage and Medically Deprived Areas teamed up with the Illinois Jaycees to survey actual needs. Results of this will provide background for a concerted program in this field.

To help meet the need for generalists and practitioners of family medicine, ISMS supported a bill making mandatory in state medical schools a Department of Family Practice. This would qualify students for Board Certification in the 21st specialty. We are happy to report the bill was enacted and many activities in this area have occurred to bring closer to reality a greater availability of physicians to the family.

There was also support for changes in curricula and methods to allow for greater numbers of family doctors and a shortened curriculum. In addition, reports of establishment of clinical centers in major cities throughout the state and new medical schools were received and given impetus. The development of an independent state Council on Continuing Medical Education was given serious thought and as of this writing has been under discussion by the Board for seven months.

Museum Mannequin

During the year several requests were forwarded to the Executive Committee, relative to a request for ISMS funds to co-sponsor a replacement Transparent Anatomical Mannequin for the Chicago Museum of Science and Industry. Total cost was estimated at \$22,000, of which ISMS was asked to contribute \$7,500.

Locations of Board Meetings

After a very pleasant meeting in Springfield in 1968, it was decided that holding Board meetings away from Chicago helped to weld ISMS into a unified body with an empathy for practitioners over the entire state. The Board met in Peoria for its October meeting and in the suburban Chicago area for its June meeting. This will be continued in the future to allow physicians from local areas to participate and feel a part of the work of ISMS. This is essential to a smoothly functioning operation.

Committee on Allied Health Education

Late in the administrative year, the Board saw fit to establish a new committee to concern itself with the matter of education and examination of persons in professions allied to the medical profession. This step was taken to ensure compliance with the highest standards of medical care on the part of paramedical and sub-medical personnel.

Designation of AMA-ERF Funds

Undesignated amounts contributed by Illinois physicians to AMA-ERF have been divided among all medical schools in the United States. The Board is going to recommend to the House of Delegates that these amounts be divided equally among Illinois medical schools.

Data Processing

ISMS has been engaged in placing its membership records on computer tapes. These tapes are wholly owned by ISMS and necessary programming, update and machine time is rented. We can be justifiably proud of being the pace-setter among state associations, as no other has yet accomplished what we have in this area; repeated inquiry is received from other states to see how

they might do the same. Initial costs were justifiably high, but continuing analysis of the operation has resulted in a reduction of over 50% in cost of operation.

Board Representation and Annual Meeting Merger

Persuant to action taken last spring, by which an investigation would be made with appropriate recommendation to follow, two committees were appointed: one would study the balance of representation on the Board and in the House between Chicago Medical Society and downstate; the other committee would investigate the feasibility of merging the annual ISMS convention and the CMS Clinical Conference. At the time of this writing some very interesting meetings have been held. However, no resolution has as yet been presented. We are continuing in earnest debate and will, through objective evaluation of what is best for the organization, come to an equitable, fair result.

Consideration of MD's Association and Medicaid

The Board received reports during the year pertaining to the Associated Physicians of Cook County Hospital. Very detailed reports of the operation were presented. Action early in the year indicated disapproval of any duplication of payment. After hearing a report from the officers of the APCCH, the Board took the matter under advisement due to the complicated interrelated processes of medical education, the delivery of medical service and the role of the third party.

Pollution Concerns

During the past year I have been privileged to be allowed to give my viewpoints to, and participate in some tours of, the Chicago Sanitary District. We are grateful for the opportunity of representing medicine in this topic of prime concern to every resident of Illinois.

Relations with Specialty Groups

The Illinois Podiatry Society requested the opportunity for closer liaison with ISMS. Likewise, the Illinois Psychiatric Society is investigating closer relationships. This is a step in the right direction, towards reducing the fractionalization of medicine and the divisiveness in some activities. It also ties in with actions of the House and the Board to offer memberships to qualified osteopaths and to invite official representatives of specialties to be ex-officio members of ISMS Councils. Only through continued effort and activity in this area will we be able to be the pace-setter and coagulant, thereby joining all of medicine in unified action.

Status of Medical Advisory Committee to IDPA

Following complete legal briefing, the medical advisory committee to IDPA was removed as an official ISMS committee. The committee is provided for in the Illinois statutes and ISMS merely nominates members to the committee. The Department of Public Aid must make actual appointments. The committee makes recommendations in medical matters, but takes no action. It has no power to act and may report to ISMS only as a matter of courtesy. This same principle may maintain with respect to the medical advisory committee to the Department of Vocational Rehabilitation.

Health Care Coordination

Several important events occurred during the year paving the way to establishment of better means of delivery of health care. One of the most important was the appointment of Dr. Albert Snoke as Coordinator of Health Services, by Governor Ogilvie. Dr. Snoke has met with the Board of Trustees and has indicated a sincere desire to set up mechanisms whereby all persons concerned with this vital area will be mobilized into a unified force to better the care of the population.

Licensing of Physicians

During the year several questions regarding licensure were presented. Expressions of discontent were received from several sources regarding delays and difficulties encountered by physicians transferring from other states. The Board appointed a special committee to work with R. and E. on the question of reciprocity, changes in the Medical Practice Act made necessary by changed curricula and greater consideration for acceptance of MDs from other areas in a shortened period of time.

Himler Report

Of vital concern to all physicians is the report and minority report of the AMA Committee on Planning and Development, the so-called Himler Report. This provides far-reaching revamping of the services and structure of the AMA. All county societies were sent a condensed version of the report so all physicians may be apprised of the content, and present viewpoints to ISMS which may be forwarded to the AMA.

Malpractice Concerns

The entire malpractice issue is of vital concern to every physician in Illinois. I have appointed a special committee to study the entire matter—what it is, how physicians may be informed, the role of ISMS, medical testimony, and so on. After repeated discussion with the Illinois and Chicago Bar Associations those groups have indicated no desire to cooperate in establishing a screening panel. ISMS may have to set up an independent panel which will assist physicians in evaluating each case.

Dues for 1971

The House, in official action, has indicated that the Chairman of the Board shall place the question of dues for the coming year on the agenda for consideration at the spring meeting of the Board. Written notice of the Board action is to be mailed to all delegates and alternate delegates, and to all officers of county medical societies. It shall also be published in the *Illinois Medical Journal* as part of the chairman's report.

Accordingly, at this time I can report that the Board of Trustees will recommend that the House approve a dues rate of \$105, as it has been in the past.

Prior to the convention, the annual audit by Peat, Marwick and Mitchell, auditors, for 1969 will be available, as well as revised budget estimates for 1970 and 1971 estimates.

Thank You

In working for you as Chairman of the Board, I have been gratified by the consideration and deference shown

me. Hopefully I have lived up to expectations, but my job has been a lot easier due to the especially fine efforts of the many Board members and our excellent Council and Committee Chairman and members.

Also, the staff has functioned most effectively in our cause. Under the capable leadership of Executive Administrator, Mr. Roger N. White, a consolidation has taken place and services to members have continued to expand and improve. My thanks to all division directors and staff at headquarters for their faithful service and significant contributions to a successful year.

Frank J. Jirka, Jr.

EXECUTIVE ADMINISTRATOR

The actions taken by the 1969 House of Delegates by resolution or through reports have been referred for follow-up activity. A report on the completion or progress on these actions will be found in the appropriate council or committee reports as presented to the House of Delegates. The revised council and committee structure, adopted by the 1969 House of Delegates, has improved the functioning of these bodies. The assignment of closely related activity to a single council and the elimination of committees, whose functions duplicate those of the councils, has reduced the number of meetings and allowed for a better staffing and operating pattern.

The staff complement of the Society has remained stable since 1964. To maintain stability, it has been necessary to establish priorities of staff services, with the most urgent needs given the greatest attention. Every effort is, of course, made to provide a minimum of service to each Society function. During the year several rearrangements in staff assignments have been made to meet changing priorities. Through this method it has been possible to create a much-needed position of Field Services Representative without increasing the overall staff complement. Heretofore, direct contact between the state office and the county societies has been quite sporadic. It has become increasingly evident that a more direct line of communication would be helpful to both the ISMS program and the programs of the county medical society. Despite extensive contacts through the *Illinois Medical Journal*, the monthly newsletter *Pulse*, the distribution of Abstracts of Board of Trustees action and other forms of written communication, many members at the local level are not fully aware of the potential for obtaining assistance on their problems through the facilities of ISMS. The District Trustees bear the official responsibility for these contacts between ISMS and the county societies. However, the limitations on their time is obvious. It is expected that the Field Services Representative will work in close harmony with the District Trustee and be supplemental to him in relating the needs of the county society to the resources available through the state society. The Field Services Representative should be particularly helpful to those societies which do not have their own staff.

Currently six executives are devoting full time to the staffing of downstate county medical societies, some on a multi-county basis. One additional full-time executive has been authorized but as yet the position remains unfilled. In addition, two executives serve under part-time arrangements and several county societies employ recording secretaries. This is in addition to the Chicago Medical Society which maintains a substantial staff. In keeping with the directive of the 1969 House of Delegates, every effort has been made to work closely with these executive staffs and to assist any county which wishes to establish offices. We

have found these executives to be most helpful in strengthening the ISMS program as well as rendering service to their own members. A meeting between the ISMS staff directors and the county society executives was held in Peoria in October. Further meetings are planned. These executives are invited to attend the ISMS Board of Trustees meetings and to participate in all appropriate medical society functions.

The Society's finances are, at all times, under the control of the Board of Trustees with close supervision from the Secretary-Treasurer and the Finance Committee (see Secretary-Treasurer's report). Since the staff plays a key role in creating many of the Society's expenditures, it is necessary that adequate controls be maintained in the day-to-day operations. The program of competitive bidding on major expenditures, announced last year, has been maintained throughout this year. Budgetary procedures laid down by the Finance Committee have been rigidly followed. Each Division Director is made responsible for adhering to the approved budget plus a system of prior approvals on large expenditures. During the year special measures have been taken to reduce the cost of the computerized membership and billing services. Rigid control over the amounts expended in computer programming have been instituted and the cost of computer processing time reduced. Some of these savings are reflected in the 1969 experience but the full effects of these reductions will be clearly evident in the 1970 experience. Full advantage has been taken of the high earning rates on short-term investment of working capital. The good experience in this category has served to offset a portion of the unavoidable loss in *Journal* revenue. During the year the Director of the Business Services Division resigned to complete his studies for an advanced degree. Due to the capable staff in this Division, it has been possible to absorb these duties without a direct replacement. Mrs. Robert (Sandie) Koebel has been advanced to the position of Business Manager and the former Business Services Division has been merged with the Administrative Division. This transfer of responsibilities has allowed the establishment of the position of Field Services Representative previously described, without additional expenditures for salaries.

The many attacks upon the profession, emanating mainly from governmental agencies, have placed added burdens upon the staff. To counter these attacks it has been necessary to increase the tempo of news releases, speech writing research for our officers and extended legislative contacts. It becomes more evident with each passing day that our major effort must be directed to reaching the public through the news media to tell medicine's side of the story and that added strength must be generated in the legislative bodies and governmental administrative agencies. One of the greatest weaknesses insofar as these dealings have been concerned, is the lack of a unified voice for medicine and the lack of a combined effort among the myriad of specialty groups. During the year, staff has put forth a special effort to maintain liaison with the specialty groups on socio-economic, legislative matters and to make it possible for these groups to relate their programs to the existing structure of organized medicine. The Society currently provides staffing services to the Illinois Chapter of the American Society of Internal Medicine. Discussions are underway for providing similar services to other specialty societies. These arrangements are, of course, undertaken with full reimbursement to ISMS for the costs involved. The previous arrangements for staff services to the Woman's Auxiliary and the Illinois Medical Assistants Association has continued.

The space available in the headquarters office for the adequate functioning of the staff has been a concern for several years. In addition to the reduced efficiency of cramped quarters for some of our employees, a new need has developed for more adequate meeting room space. Within the last several years most hotels have adopted the policy of charging for their meeting rooms in addition to the food service. At the present time the Society has only a small conference room which will not accommodate many of the meetings. Since catered food service arrangements are available in the building, a substantial savings could be realized on both food and meeting rooms if space were available. Accordingly, negotiations are underway to acquire additional space immediately adjacent to the offices on the 20th floor. Whether or not this development takes place, will depend upon the movement of other tenants within the building which will occur about May 1, and the price for the additional space. The foresight of the Board of Trustees in acquiring a 10 year lease on the existing space in 1965 has paid handsome dividends in view of the sharply escalating costs of office space.

In conclusion, I should like to pay tribute to the dedicated services of members of the Board of Trustees and the many council and committee members who have made the work of the Society go forward in a highly effective manner during the year. These physicians have contributed willingly of their time and energies at great sacrifice to themselves and their families. On behalf of the staff, I should like to express particular appreciation to Dr. Frank J. Jirka, Jr., Chairman of the Board and the other officers who have given excellent guidance and direction to us. Their inspiration has challenged the staff to higher levels of achievement. Finally, I should also like to pay tribute to all of the staff members for their dedicated service. Their loyalty and devotion to the Society's program has, in many instances, been above and beyond the normal requirements.

Roger N. White

SPEAKER OF THE HOUSE OF DELEGATES

Your speakers are gratified to report that the 1969 House of Delegates completed an unusually busy agenda with a minimum of confusion. The reference committees are to be commended for the excellent manner in which they conducted their open hearings, completed their work in executive session and presented excellent reports to the House. It is interesting to note that your Speaker received only one criticism regarding the 1969 meeting.

The committee and council reports, reports of officers and trustees, and special reports are contained in this handbook. As Speaker may I take this opportunity to ask all delegates to review the reports carefully and discuss any controversial problems or policy-making statements with the members of your county medical society or your branch society, so that you may present their views to the reference committees.

It is very important that you attend all three meetings of the House of Delegates (Sunday, Tuesday and Wednesday) and that you attend the reference committee meetings on Sunday at 7:00 p.m.

A delegate should see that all material is sent to headquarters before the first meeting of the House, so that our staff will have time to reproduce it and distribute the material to the members of the House. Please note where it is referred and plan to attend the reference committee meeting and present your society's views.

Remember that the resolutions and reference committee reports have no standing and are not official till they have been adopted by the House.

All members of the ISMS are invited to attend the open hearings of the reference committees and to present their views.

Your delegates have the responsibility to vote and represent your branch or county society at the *SECOND MEETING* of the House of Delegates on Tuesday afternoon, May 19.

The election of officers, trustees, delegates and alternate delegates to the AMA takes place on Wednesday morning, May 20, at the *THIRD MEETING* of the House of Delegates. Following the election, the remaining reference committee reports will be heard and acted upon.

Following the adjournment of the meeting of the House of Delegates for 1970, the headquarters staff will prepare and mail to each delegate, alternate delegate, officer, trustee, and all presidents and secretaries of branch and county societies, a brief summary of the actions taken, so that reports may be made to the constituent societies.

The meetings of the House of Delegates this year will be:

SUNDAY, May 17

2:00 p.m. Committee on Credentials

3:00 p.m. **OPENING MEETING OF THE HOUSE**

Introduction of Resolutions, reports, etc. and referral to the proper reference committee by the Speaker

7:00 p.m. Reference Committee meetings

Open meetings, to which all members of the ISMS are invited

TUESDAY, May 19

1:30 p.m. Committee on Credentials

2:00 p.m. **HOUSE OF DELEGATES** (Second Session)

To hear and act upon the reports of the reference committees that are ready to report

WEDNESDAY, May 20

9:30 a.m. Committee on Credentials

10:00 a.m. **HOUSE OF DELEGATES** (Third and final session)

To hear and act upon the remaining reference committee reports

Election of 1971 officers, trustees, AMA delegates and alternate delegates

Induction of J. Ernest Breed into the office of President

Your Speaker intends to ask the House to use the "Standard Code of Parliamentary Procedure by Sturgis" (Second Edition, New and Revised) at this meeting. It has a section that explains the use of reference committees. (Note: Dr. Bornemeier helped by furnishing material for this section. "Sturgis" has been adopted by the House of Delegates of the AMA.)

Any comments or suggestions that will improve the efficiency of the procedure of this House will be most welcome and sincerely appreciated by the Speaker.

Maurice M. Hoeltgen

VICE-SPEAKER OF THE HOUSE OF DELEGATES

The actions of the Vice-Speaker during the past year have followed the policy as outlined in the constitution and bylaws.

I have assisted the Speaker, Dr. Maurice Hoeltgen, in the conduct of the affairs for the House of Delegates and the selection of members of the reference committees.

The use of the reference committee substitutes in attendance at the reference committee hearings worked well last year. We hope to continue similar assignments in the future.

My function is to serve the ISMS, the House of Delegates, and the Board of Trustees. I hope that I may continue in this area.

Paul W. Sunderland

DELEGATION TO THE AMA

The importance of a well informed and smoothly functioning delegation has been stressed for the past several years.

To help contribute to this ultimate aim for the Illinois delegation, all delegates and alternate delegates are invited to attend all regular meetings of the Board of Trustees during the year. There are eight delegates and eight alternate delegates who are not Board members and the need to keep the entire delegation informed is obvious. In addition, a delegate and an alternate delegate are assigned to each reference committee at the AMA meetings and they report back to the delegation at each breakfast meeting for discussion of reference committee activity and to consider a course of action.

At the annual meeting in New York, July, 1969, Dr. Walter C. Bornemeier was elected—by acclamation—as President-Elect of the AMA, and Dr. Burtis E. Montgomery was re-elected by acclamation to the Board of Trustees. (He was subsequently re-elected as Chairman of the Board of Trustees.) A reception for Dr. Bornemeier and Dr. Montgomery was held with the support and cooperation of the Chicago Medical Society.

We will not have any candidates for elective positions of the AMA to present in June. The annual meeting will be a very busy one for the delegation with reports on several important questions.

At the 1969 New York meeting, Dr. H. Close Hesseltine served as Chairman of Committee A, Insurance and Medical Service. Dr. Edward W. Cannady served as a member of Committee G on Miscellaneous Business. Dr. William K. Ford served on Committee D on Hospitals. At the clinical meeting in Denver, Dr. Leo P. A. Sweeney served as chairman of the reference committee on Board of Trustees and Dr. Jacob E. Reisch as a member of the Committee on Credentials.

Resolutions submitted by the Illinois delegation at the annual meeting in New York in 1969, and the action taken:

#50A-69 "Use of usual, customary and reasonable fees as payment by Vocational Rehabilitation Agencies."—Adopted.

#51A-69 Combined with similar resolutions and substitute resolution. "Resolved that the AMA
& urge a reassessment by Congress of its interest
#52A-69 and priorities in relation to Title XIX."—Adopted.

#53A-69 "Regarding Joint Commission on Accreditation and new regulations proposed."—Not Adopted.

#54A-69 "Labeling of Prescriptions with Drug, Dosage and Amount Prescribed."—Adopted with referral to Board of Trustees and its Council on Legislative Activities.

The following resolutions were submitted and acted upon at the clinical meeting in Denver in November:

#14C-69 "Exchange of Public Affairs Program—Material and Ideas."—Adopted.

- #15C-69 "Educational Opportunities for Medical Students, Interns and Residents."—Adopted—as amended
- #16C-69 "Liaison with part B Medicare Carriers." Resolution 115 (A-69) adopted by House will substantially achieve the intent of R-16.—Not Adopted.
- #41C-69 "Student Loan Interest Fund." REFERRED to AMA-ERF for study and appropriate action.
- #53C-69 "Elevation of Medicaid Payments." Resolved that AMA institute appropriate action to request that the Department of HEW eliminate this situation and increase Medicaid payments to the Medicare level (of usual, customary and reasonable).—Not Adopted—Adoption would be inconsistent with AMA Policy.

At the clinical meeting of the AMA in Denver several reports were of special interest. Probably the most important was the report of the Committee on Planning and Development, chaired by Dr. George Himler, and the minority report by Dr. John H. Budd. Our President, Dr. Edward W. Cannady, advised that this report be presented to the Board of Trustees and that study of the entire report be encouraged at the county level in Illinois, with a report back through the trustee in each district. The delegation adopted Dr. Cannady's advice by formal action and recommended that a summary of the report prepared by the Wisconsin State Medical Society be sent to each county medical society. The full report was to be studied by all Board members, the Delegation, and all Council and Committee Chairmen.

The AMA House of Delegates considered and adopted three recommendations relative to the report of the Committee on Planning and Development and minority report as follows:

1. That a permanent Committee on Long Range planning be appointed.
2. That an ad hoc committee be appointed, to consist of nine members (appointed by the Speaker of the House). This ad hoc committee to have the following charge:
 - a. To receive the report of the Committee on Long Range Planning and Development, as well as the Minority Report and all reviews, correspondence and transcript of the proceedings.
 - b. To study and make recommendations concerning the structuring of and the charge to the permanent Committee on Planning and Development and to report these recommendations to this House of Delegates at the Annual Convention in 1970.
3. This House of Delegates can better act on the specific recommendations of the report of the Committee on Planning and Development and the minority report *with the benefit* of individual resolutions to be submitted by the component and CONSTITUENT STATE ASSOCIATIONS OR SOCIETIES. Therefore, the two reports shall be transmitted to the constituent state societies for such specific action by their governing bodies as they deem warranted, it being understood that all recommendations will be considered at the Annual Convention in 1970. These recommendations have been presented to our Board of Trustees.

The following members of the Illinois delegation are serving the American Medical Association as elected officers, or as appointed members of either councils or committees:

President-Elect—Walter C. Bornemeier, Chicago
Board of Trustees—Burtis E. Montgomery, Harrisburg
Chairman of the Joint Commission, Accreditation of Hospitals—H. Close Hesseltine, Chicago
Committee on Health Care

Financing—H. Close Hesseltine, Chicago,
Consultant
Council on Voluntary Health
Agencies—Edward W. Cannady, East St. Louis
Disability Insurance Claims
Review Committee—Maurice M. Hoeltgen,
 Chicago, *Chairman*

At the last meeting of the House of Delegates on Wednesday, Dec. 3, 1969, the delegation paid tribute to the Illinois physicians serving at their last meeting of the AMA House of Delegates as follows:

Dr. H. Kenneth Scatliff, Chicago, who has served as a delegate from Illinois since 1952 and as an alternate delegate from 1944-1951.

Dr. Arthur F. Goodyear, Decatur, who has served as a delegate since 1960 and as an alternate since 1954.

Dr. Frank Fowler, Chicago, who has served as a delegate since 1959 and as an alternate delegate from 1956 to 1959.

Dr. Newton DuPuy, Quincy, who has served as an alternate delegate since 1961.

As President of the Illinois State Medical Society, Dr. Edward W. Cannady presented the Illinois State Medical Society check in the amount of \$186,000 to the President of the AMA-ERF.

Your delegation is busy with plans for the 1970 Annual Convention which will be held in Chicago in June. Seated with us at that time will be the following new members of the delegation as of Jan. 1, 1970:

Drs. Edward A. Piszczek, Philip G. Thomsen and Theodore Grevas as new Delegates, and Drs. Morgan M. Meyer and Francis W. Young as Alternates.

William K. Ford, *Chairman*
 H. Close Hesseltine, *Secretary*

PRESIDENT OF THE WOMAN'S AUXILIARY

"By the rivers gently flowing, Illinois, Illinois," . . . these words of Charles H. Chamberlin have come to have new meaning for me . . .

As president of the Woman's Auxiliary to the Illinois State Medical Society it is an honor and a privilege for me to report on our activities for the year 1969-70.

The Auxiliary's primary objective to assist the Illinois State Medical Society in its program to better the health care for all the people has involved over three-thousand doctors' wives in Illinois.

Our year began with the greatest vote of confidence ever to come to our Medical Auxiliary, that of being invited to join and take part in the 1969-70 President's Tour of ISMS. The results of this recognition and exposure have had immeasurable and rewarding effects and we strongly urge that this "team effort" be continued.

While attending the National Convention in New York we realized the impact of the deeds and programs of the Medical Auxiliary. The national theme "Active Leadership in Community Health With The Accent On Youth" added to strengthen our own Illinois theme of CHIC-Children and Involvement in the Community.

It is now appropriate to measure performance against ideal, for there is something of intrinsic value in each and every one of us, and slowly the talents of the women of the medical auxiliaries in Illinois are coming to fore. The annual reports of the officers, councilors, chairmen and county presidents will reflect the achievements, accomplish-

ments and participation of our members in community programs.

We have been privileged to have representation on the following ISMS Committees: Aging, Benevolence, Cancer, Disaster Medical Care, Public Safety, Legislation, Membership, Mental Health, Public Affairs, Religion and Medicine, Scientific Assembly (Convention) and Nursing.

Our membership to date totals 3,100, a slight increase; however, we look to the day when dual membership will prevail and Illinois will take its place among the nation's leaders.

We happily report that on June 10, 1969 at the Logan Hotel in Murphysboro, we organized Jackson County. Twenty ladies became members and the charter will be presented at this annual meeting.

Illinois was presented a membership recognition award at the national convention for the outstanding work achieved in teaching and reaching its members through Program Enrichment. This program was repeated last November with outstanding speakers and excellent attendance.

Membership Citation Awards are to be presented at our Convention hopeful of spearheading an increase in membership. Our president-elect has stressed her five W's—Women Who Work Will Win.

A fact brochure was developed and distributed throughout the state so that our purposes and objectives could be known at a glance.

The county reports are not complete at this writing; these reports will appear in our convention handbook.

Efforts continue to be intensified in the areas of AMA-ERF and our Benevolence Fund. Illinois women will man AMA-ERF booths at the AMA Convention this June and the sales from this effort will be credited to the AMA-ERF Auxiliary Fund. Our own fund this year will exceed \$6,000.00.

When "The Auxiliary Told Its Story" at the national fall conference for presidents and presidents-elect this chairman shared in the program, presenting "Illinois Tells It Like It Is."

Children and Youth is a new, fast growing committee. Our goal is to build a strong family unit through family activities and involvement. We look forward to our participation in the "White House Conference for Children and Youth."

Through our Health Career Programs, four area workshops were held throughout the state in conjunction with the Health Careers Council of Illinois. Numerous contributions and scholarships have been awarded to young adults in related health fields. Our auxiliaries have also been involved in preceptorships.

The auxiliary archives are complete to date and this committee, along with our historian, has written a complete history of our organization and its achievements through the years.

Community Health encompasses the areas of Mental, Rural and Urban Health. Many new ideas have been developed as well as package programs. In this area we can be of great service by educating our communities of the existing problems especially in the fields of drug abuse, sex education and environmental health.

We are most grateful to the State Society for the space allotted us in the monthly publication, *Pulse*. We feel that through our award winning "Pulse of the Doctors' Wife" we reach all the wives of physicians in Illinois.

Home-Centered Health Care is one of our newest programs and is supported by ISMS in cooperation with their committee on aging. This area covers Homemaker Service,

Meals Service and Volunteer Friendly Visitor Training.

International Health continues to have great appeal for auxiliaries who collect medical supplies, books, etc.

A highlight of our year was participation with the Medical Society in its Public Affairs Round-Up in Washington, D.C. We also look forward to our "Public Affairs Breakfast With Our Doctors," a first at this convention. We continue to encourage support of IMPAC and AMPAC by our members.

Our Program Development chairman keeps the counties current on the latest materials and programs available and how they can be obtained. Package programs include Teenage Venereal Disease, Youth and Health Fitness, Mental Health of Children, Health Careers, Immunization, Block Mother Plan, Homemaker Service, Sex Education, Alcohol and Drug Abuse.

The number of members-at-large continues to increase and every effort has been made to keep "in touch" with these members, keeping them informed. They have been invited to participate at district meetings and convention.

This is the year for revising our bylaws. Many hours of careful study, consideration and deliberation have gone into this effort in an attempt to have our bylaws current, and applicable.

Safety continues to be a prime interest to all. Illinois was awarded honorable mention at the National Convention last June for our efforts in this area. We have also developed our own film entitled "Lost—One Sitter," to be used to educate baby sitters in conjunction with the GEMS program.

The Auxiliary supports one WA-SAMA chapter in our state. We look to the day when these young women will be the new members and leaders of our organization.

On advice from our advisory committee, a pilot program will be initiated in July when we hope to hire a part-time executive secretary in an effort to make ours a more cohesive and efficient organization.

As president I was privileged to attend all district meetings and participated in their programs. Several counties were also visited as well as attending the national regional workshop in Kansas City, Mo. It is our feeling that this effort on our part in getting to know our members has far reaching results.

This chairman will humbly serve as chairman of the Annual Convention of the WA-AMA in Chicago, in June.

The women of the Auxiliary also join with the doctors of Illinois in the pride that they will share when the single honor of leading the nation's doctors will come to one of our own Illinois physicians as he is installed as president of the AMA in June.

Challenged with goals greater than ever before, we are ready to meet this challenge and take our place among the leaders of our communities.

The Woman's Auxiliary to the Illinois State Medical Society is most grateful to the Executive Administrator and his able staff for their cooperation and efficient service in fulfilling our needs and requests.

My sincere appreciation goes to the Advisory Committee for its guidance and support, and a very special thank you to Dr. Cannady for his trust, encouragement, response and help in promoting Auxiliary.

"O'er thy prairies verdant growing, Illinois, Illinois" ... Yes, Illinois, it has truly been an honor and a privilege for me to come to know your beauty by serving the doctors of Illinois through our Medical Auxiliary.

Mrs. Sherman C. Arnold

Committees of the Board of Trustees

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The Advisory Committee to the Woman's Auxiliary met with the President, President-Elect, Past-President and others at a breakfast meeting on January 18, 1970. In general the Auxiliary has had a good year. A "workshop" presented at the Sheraton Blackstone Hotel on November 10, was quite successful. The emphasis was upon programs, but in addition, Mr. Hawkinson of Smith, Kline and French conducted a class in public speaking.

Of great concern to the officers is the gradual decrease in membership in the Cook County Branch of the Society. It was hoped that this difficulty can soon be corrected.

The Auxiliary has encountered some confusion in their liaison with the I.S.M.S. office. Several years ago it was thought advisable to have them contact the same individual rather than requesting information or service from several different departments. This has worked somewhat better, but puts a strain upon the executive administrator. At this meeting it was suggested they be empowered to employ a part-time secretary, who would then assume responsibility for their needs. The Advisory Committee thought this was an excellent idea.

J. Ernest Breed, *Chairman*

Edward W. Cannady

Philip Thomsen

COMMITTEE ON COMMITTEES

The Council and Committee structure as amended and adopted by the 1969 House of Delegates appears to be functioning efficiently and effectively.

When this became apparent at mid-year, a questionnaire was sent to the respective Council chairmen and members of ISMS staff. We are grateful for the response. The suggested changes are not difficult to resolve and all respondents expressed willingness to continue under the present Council and Committee organization.

In view of the lack of sufficient agenda, from year to year, it was apparent the requirement of this committee to meet annually is redundant. Therefore, it was recommended and approved by the Board of Trustees at the January meeting that the Constitution and Bylaws Committee shall consider removing the word annually from CHAPTER VI, Section 5, Paragraph D #5. (Thereby placing it, too, on an ad hoc basis).

At the January 1970 meeting of the Board of Trustees the addition of two new committees was approved:

1. Under the Council on Economics and Governmental Health Programs—Peer Review Committee (also to be established at district level).
2. Under the Council on Education and Manpower—Committee on Allied Health Education.

The description of *Responsibilities and Purposes* for the latter is: As a means of alleviating the effects of a physician shortage that exists in virtually all parts of Illinois, it has been suggested that allied health personnel be educated and trained to perform certain medical procedures heretofore done only by physicians. This committee should be concerned with the specific types of medical procedures which could be done readily by trained non-physicians and what education and training is needed to qualify such individuals as "assistant physicians." The committee necessarily will concern itself with the legality of this activity

under the Illinois Medical Practice Act, the implications of licensure and relations with the Illinois Department of Registration and Education, and liaison with medical schools and other educational institutions established for training of the personnel involved.

Darrell H. Trumpe, *Chairman*

William A. McNichols, Jr.

Paul Youngberg

Warren W. Young

COMMITTEE ON CONSTITUTION & BYLAWS

The suggested amendments made by the Committee on Constitution & Bylaws (to reflect some of the requests from various sources) will, if adopted by the House of Delegates, result in the following changes:

- (1) Remove "who is a graduate of a medical school approved in the United States or Canada" as a stumbling block for the admission of graduates of Schools of Osteopathy.
- (2) Change in the method of selecting the meeting place for the annual convention so that it will read:

The meeting place for the annual convention shall be determined by the House of Delegates from a list of cities extending invitations, subject to investigation of the facilities and recommendation by the Board of Trustees.

- (3) Under "Duties of Officers," the provision of bond for the secretary-treasurer has been removed and will be found in CHAPTER VI. Board of Trustees.
- (4) All committees of whatever nature, have been placed in one CHAPTER, and in many cases no change has been made, but the material has been lifted from one area and placed in another. This will be clearly outlined in the material for distribution to members of the House.
- (5) Minor changes have been made in the duties of some of the Board committees . . .

a. Committee on Publications "shall review, edit and supervise the publication of other materials as directed by the Board" rather than the present statement:

"It shall review, edit and approve all material published by the Society."

b. Added under the "Policy Committee"

It shall make recommendations for future policy by Board resolution to the House of Delegates.

c. In the Section dealing with the Committee on Committees, the words "at least" have been added in Paragraph 1, line 3, so that it reads:

The Committee on Committees shall review at least annually the purpose, activity and structure of all committees and councils, or propose such additional committees and councils as appear to be required for the efficient conduct of the business of the Society.

In CHAPTER IX, Part 2, Section 1, Organization of Councils, Paragraph D.

(6) Provided that—

Only active members of the ISMS, not AMA delegates or officers of the ISMS, may be appointed to a Council. Any ac-

tive member of the State Society may be a member of a sub-committee or a special committee. Officers and AMA Delegates may be appointed advisers to any committee.

In the same CHAPTER IX, under Part 3, House of Delegates Committees, Section 1 shall read:

Section 1. Appointment. *Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment from among the members of the House, such committees as may be deemed expedient by the House of Delegates.*

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

The Constitution and Bylaws Committee met on Jan. 3 in preliminary session, attended by Drs. Razim, Brislen, Fox and Ring. A full meeting was conducted on Jan. 24, with all members of the committee present, together with Mr. Pfeifer, legal counsel, Mr. White, executive administrator, and Dr. Lake, consultant.

The second full meeting of the committee was held Feb. 21, and the actions taken at the time prepared for the House. Among the items reviewed are: (1) membership problems (some of which have been raised by the membership department at headquarters); (2) whether or not a change should be made to provide for membership of ISMS members in the SAMA, as a means of offering further assistance in the development of additional physicians for Illinois; (3) peer review; and (4) specialty society representation in the House of Delegates.

Edward A. Razim, *Chairman*

Andrew J. Brislen

William H. Walton

David S. Fox

Fredric D. Lake, *Consultant*

John Ring

Mr. Frank M. Pfeifer, *Legal Counsel*

THE EDUCATIONAL & SCIENTIFIC FOUNDATION

The Educational & Scientific Foundation of the ISMS was established in 1961. The Foundation is incorporated in Illinois and financial support is tax deductible. The Foundation is dedicated to the advancement of medical knowledge and the education of the public, particularly in the State of Illinois. The Foundation is managed by a Board of Directors which consists of the ISMS President, the immediate Past-President, the Secretary-Treasurer and the Chairman of the Board of Trustees. The immediate Past-President serves as Chairman of the Foundation Board and the Secretary-Treasurer of the Society occupies the same post in the Foundation. There are three classes of membership in the Foundation:

- 1) Fellows of the Foundation are physicians holding regular membership in the Foundation following the contribution of \$100 or more.
- 2) Associate fellows are non-physicians holding regular membership in the Foundation following a contribution of \$100 or more.
- 3) Honorary fellows are individuals whom the Foundation's Board of Directors elect to membership because of their exceptional service to the organization and its goals.

During the year the Foundation served as a receiving and disbursing agent for these educational projects:

DuPage County Preceptorship program supported by a

\$1500 grant from Sears Foundation; Student AMA Summer Job-Education Project supported by \$750 grants each from the Illinois Academy of General Practice, the Illinois Hospital Association and the ISMS; ISMS Socio-economic survey supported by \$4,654.67 grant from the Illinois Medical Journal Improvement Fund; and Scientific Speakers Bureau supported by a \$5,000 grant from Merck Sharp & Dohme.

Following is a list of county medical societies using the service in 1969, the number of meetings using bureau speakers and the number of physicians who spoke at these meetings:

Adams County—3 meetings, 3 physicians
Bureau County—8 meetings, 8 physicians
Champaign County—2 meetings, 2 physicians
Southern Cook County—1 meeting, 1 physician
Clinton County—1 meeting, 1 physician
Coles—Cumberland County—5 meetings, 5 physicians
De Kalb County—5 meetings, 5 physicians
DuPage County—1 meeting, 1 physician
Greene County—1 meeting, 1 physician
Kane County—1 meeting, 1 physician
La Salle County—10 meetings, 8 physicians
Livingston County—5 meetings, 5 physicians
Montgomery-Macoupin Counties—6 meetings, 6 physicians
McDonough County—2 meetings, 2 physicians
McLean County—1 meeting, 1 physician
Stephenson County—1 meeting, 1 physician
Vermilion County—1 meeting, 1 physician
Lee-Whiteside Counties—9 meetings, 9 physicians
Williamson County—1 meeting, 1 physician

In addition to its operating grant, Merck also contributed another \$1000 for revising and reprinting the Speakers Bureau Roster.

The Foundation also received \$1,042.23 from the Kankakee County Medical Society and Auxiliary from a benefit concert to support medical education at the local level.

In addition, checks were received from several individual physicians interested in starting a special loan fund for medical students experiencing financial hardship because of the tight money situation that existed during the year.

Philip G. Thomsen, *Chairman*

J. Ernest Breed

Frank J. Jirka, Jr.

Jacob E. Reisch

THE COMMITTEE ON OSTEOPATHIC PROBLEMS

Over the past few years, the Committee on Osteopathic Problems has made slow but consistent progress in its efforts to arrive at amicable relations between our two professions. This has been especially true since many of the recent graduates who prefer to be classified as "osteopathic physicians" have been eligible to take, and have successfully passed the examinations to practice medicine in all its branches in Illinois.

The first step in cooperation was to have approved by the House of Delegates, a policy statement regarding voluntary professional association with a Doctor of Osteopathy.

This year the House will be asked to approve the following statement, prepared by the Policy Committee and approved by the Board of Trustees for presentation:

Society Membership for Osteopathic Physicians

Osteopathic physicians who meet all qualifications for membership, base their practice on the same scientific principles as those adhered to by members of the AMA and are licensed to practice medicine in all its branches in Illinois, may be accepted as active members by the county medical

societies throughout the state and be accorded all privileges of full membership at the county and state levels and be so reported to the American Medical Association for acceptance at that level.

The committee hopes this will be one of the last steps necessary to develop and maintain better relationship with ethical osteopathic physicians. The action still leaves the matter in the hands of the county society, the sole judge of its membership and makes it necessary that all qualifications and abilities demanded of Doctors of Medicine, be possessed by the osteopathic physician applying for membership.

Arthur F. Goodyear, *Chairman*
William E. Adams William H. Schowengerdt
Paul P. Youngberg

POLICY COMMITTEE

The Policy Committee has been asked to submit for the consideration of the House of Delegates, policy statements in four areas as follows:

Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable. Representatives to serve in this capacity may be nominated by the specialty society, approved by the Board of Trustees of ISMS, and designated as consultants to the council without vote, in compliance with the Bylaws.

ISMS Membership for Osteopathic Physicians

Osteopathic physicians who meet all qualifications for membership, base their practice on the same scientific principles as those adhered to by members of the AMA, and are licensed to practice medicine in all its branches in Illinois, may be accepted as active members by the county medical societies throughout the state, and be accorded all privileges of full membership at the county and state levels and be so reported to the American Medical Association for acceptance at that level.

Shortage of Nurses

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.

Impartial Medical Testimony

The ends of justice are served when impartial medical witnesses are available to give testimony. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.

The Policy Committee will make a detailed study of the Manual as amended by the 1969 House, and submit a supplementary report if any changes seem indicated. A copy of the 1969 Manual will be distributed in the packet

to each member of the House of Delegates at its opening meeting.

William E. Adams, *Chairman*
James B. Hartney Arthur F. Goodyear

PUBLICATIONS COMMITTEE

"This is a far better graphic publication than the average state medical journal." So begins a brief graphics evaluation of the American Society of Association Executives. The study of the *Illinois Medical Journal* was conducted by Prof. Miller at the University of Missouri School of Journalism, one of the outstanding schools in this field.

Our committee concurs with such a statement. We undoubtedly have one of the most outstanding state journals. This is due to the fact that we constantly have been striving for improvement. Areas which we realistically recognized as weak were improved and modifications are being made in each issue. The size of the book has been maintained even in light of a slight drop in advertising pages. Other state books have consistently been getting thinner—some contain as few as 64 pages—while the *IMJ* averaged 112 pages (or 126 if the Convention and Reference Issue pages are included). No issue was less than 104 pages.

The evaluation goes on to state: "*IMJ* is trying for appearance. It shows it is not wedded to professional stodginess . . . the Socio-Economic News is the best-designed feature . . . covers, individually, are high in quality. Individually they are very interesting . . ." We appreciate these laudatory remarks—they attest to our continuing concern for a truly useful, representative journal. Much of the improvement is due to the guidelines established two years ago, as reported last year in the annual report of this committee. Hopefully we will eventually meet the needs and desires of each member.

Our continuing features and special articles again provided definite service to the membership. "Membership Forum" began to be utilized by the members as a medium of expression. The analyses of the *IMJ* Membership Opinion Surveys (1968 and 1969) provided insight into the needs and desires of the members. The survey will be reported later in this report. Other feature items which the committee feels contributed materially to the *Journal's* contents included a series of articles explaining IDPA payment procedures and policies, the completion of the medicine and religion articles, publication in series of the papers from the Nutrition Conference, articles on the history of medicine, and so on. These have all balanced the content of *IMJ*.

Continuing features also furnished edifying material for the reader. The President's Page, Socio-Economic News, Practice-Management News, Insurance Questions, Public Affairs Library, and others are in this category. These items help Illinois physicians in forming opinions and making decisions in many concerns.

Abstracts of Board Actions were reported regularly, appearing five times during the year, to keep the membership informed of State activities. The Reference Issue was published in October, again giving the most comprehensive listing available of all medical and health related facilities in the state of Illinois. Unfortunately, the Medical-Legal section of the issue was delayed until the December issue due to extensive revisions and additions to the Illinois statutes. The content of the Reference Issue is being re-evaluated for 1970.

On balance, the *Journal* again remained as close as possible to established ratios; of the total pages published 35% were advertising. Excluding the special sections of the Convention and Reference Issues, which must be considered distinctively and separate, the ratio becomes 38½% advertising and 61½% editorial. The guide is 40:60. In light of the fluctuation of advertising during the year this is considered well within operational norms.

Net income from *Journal* and *Pulse* operations showed a moderate decline in 1969 compared to 1968. The drop was not alarming at any specific time, but was somewhat discouraging, and all such decreases are disappointing. Although the official audited figures are not available at this writing it appears that revenue will be down by about 16%. Such a reduction, however, must be evaluated by comparison. Compared to neighboring states this is a smaller reduction than they experienced, a tribute to the acceptance of the IMJ and its market and to the efforts of staff to keep things on target and generate increased revenue.

The reduced income can be attributed to fewer advertising pages. The drop could have been due to any of several factors or various combinations. Uncertainty in the market, lack of new products, slowness of FDA in certifying new products, FDA regulation of advertising and full disclosure, or tight money. Deviations such as these happen year-to-year and seem to be cyclic. They reflect the changes in direction of spending by suppliers.

As of the first of 1970 the outlook is optimistic—contrary to the predictions of the “experts.” We hope the year will be good in spite of the imponderables we face. Our first quarter is up 18% over 1969, and if this trend holds some of the decrease of 1969 will be offset.

The committee, acting during the year, voted to maintain the 40:60 advertising to editorial ratio for 1970. It also adopted a policy of accepting institutional advertising from the Wine Growers Association and that malt liquor advertising will be accepted so long as such treats the nutritional aspect of the product. In addition, a small increase of 10% in the black and white advertising rate was adopted. The first increase of any kind in three years.

A new law enacted by the current U.S. Congress, the so-called Revenue Reform Act of 1969, codifies IRS regulations covering taxation of non-related incomes of tax-exempt associations such as ISMS. The total impact or application of this tax against the *IMJ* is not predictable as this is written. We have established a basic cost-accounting system for the *IMJ* and hope that the expenses allocable against the *Journal* balance off receipts.

To cite an interpretation of the act: “Presently, the profits of exempt organizations from sale of advertising in periodicals, journals and magazines they publish are unrelated business income unless the advertising activities ‘contribute importantly’ to the accomplishment of the exempt purpose. **Reg.** 1.513-1, in effect for taxable years beginning after December 12, 1969, thus is aimed at removing an ‘unfair competitive advantage’ of exempt organizations over other publishers.

“Solicitation and publication of commercial advertising do not lose their identity as a trade or business even though the advertising is published in an exempt organization’s periodical which contains editorial matter directly related to the exempt purposes of the organization. To determine whether an advertising activity contributes importantly to the exempt function depends on the facts and circumstances in each case.”

As a service to the membership, a new line item in budgeting has been established. By means of this an amount

of *IMJ* ad revenue will be set aside, on a monthly basis, into the Educational and Scientific Foundation. This continuous fund will allow services to the membership through the *IMJ*, improvements in publications and communications and development of new features, improvements in medical journalism throughout Illinois, and surveys of the membership to determine opinions, needs and desires.

Another service available to the membership and advertisers proceeds through the ISMS owned computer tapes on members. The cost of the data processing is shared between the *IMJ* and other divisions. This entails programming time, rental of computer time, and print-out labels. The service includes print-outs of all needed mailing labels, county listings, specialty listings, and so on. ISMS can justifiably be proud of this accomplishment, begun two years ago, as the first state medical society to have this capability. Although the system is relatively new it is proving its merit and justifying the original investment. With our competent staff supervising this operation, returns on dollars invested are increasing as actual costs are being reduced.

The second *IMJ* Membership Opinion Survey was sponsored by the *IMJ* from the Publications Grant in the Foundation. This afforded all members the opportunity of being heard. Over 38% responded, compared with 34% in 1968: remarkable! The results of the survey formed the basis of a series of *IMJ* articles. These again showed the unanimity of practitioners in Illinois. And extension of the survey to students, interns, and residents allowed a greater field of opinion to be tested. The results of these surveys have been most gratifying and have provided insight and knowledge as well as ammunition.

Pulse

Pulse continued through 1969 and into 1970. Roche Laboratories continued to sponsor this widely-read newsletter. It is devoted to publicizing ISMS activities, members, and the Auxiliary. The materials presented are eclectic and the acceptance of this periodical has been most gratifying. The committee expresses its deepest gratitude to Roche for its continued support of this venture in improved communication.

“What Goes On . . . in Illinois”

Of course, “What Goes On” has been out-of-print for over a year. However, efforts have been and still are underway to have another rendition of WGO, either as a separate publication or a *Journal* tip-in. This will continue to be explored so various programs in continuing education will be presented to all Illinois physicians.

Staff Organization

During the year the Publications Division was reorganized to return the advertising functions to this division from the Business Services Division. Also, all mail and distribution functions were assigned to this division. Thus, the Publications Division is furnishing all editorial (but not all reporting), production, advertising, printing, reproduction and distribution services for the ISMS. In addition, other special services are furnished as required.

Thank You

The Committee offers its gratitude to all who assisted in the work of publications and to the various councils and committees who have given time, counsel and co-operation.

Also, the resourcefulness, competence and dedication of the staff is commendable. We think we have one of the finest publication teams in the U.S. in the field of medical association publishing.

Mr. John Kinney, advertising manager and his secretary, Mrs. Marge Horn have organized our contact file and tickler system, as well as the billing and invoicing, to be highly effective. Our editorial assistant, Mrs. Lauren Barnett left to join the National Association of Blue Shield Plans and was replaced by Mrs. Michaelyn Sloan who has demonstrated a fresh eagerness to further upgrade our publications. Mr. Allen Ford and Mr. Harry Josephson have performed dutifully in the printing and distribution departments. Director of Publications and Managing Editor Richard Ott, and his secretary, Miss Sandra Slowik, have given much of themselves in the cause of our publications. Thanks also to Dr. Van Dellen, *IMJ* editor, and all the others adding to the excellence of our publications.

Jacob E. Reisch, *Chairman*
Frederic D. Lake Warren W. Young
Charles K. Wells

EDITORIAL BOARD

The Editorial Board met to discuss many items of concern in maintaining the *Illinois Medical Journal* as one of the leading state medical journals.

An initial concern was the composition of the board, the number of members as well as involvement of people representing different specialties. Initial recommendations to the Publications Committee were referred back to this Board and a restudy resulted in further recommendation regarding concepts such as contributing editors, slight enlargement of the Board and so on. These recommendations have been made to the Publications Committee which will consider this matter further. The definite role of the Editorial Board also was a point of discussion and it was agreed that the Editorial Board would concern itself with obtaining clinical materials and development of good medical items for the *Journal*.

Having heard several reports on the numbers of manuscripts backlogged, indicating the acceptance of *IMJ* as a good medium of expression, it was generally agreed that solicitation of manuscripts would not be necessary for some time. However, lines of communication are to be developed with the several medical schools in Illinois to enable procurement of timely articles and to develop a rapport with the research faculties.

Several series of articles have been carried in the *IMJ* during the past year. These include the Medical Progress and Surgical Grand Rounds sections. In addition, a short series was run by the Illinois Department of Public Aid, and four articles were run in the areas of History of Medicine and Medicine and Religion. Five papers from the Nutrition Symposium were produced in five installments and a new discontinuous series on the Medical Aspects of Sports has recently been begun. Attempts will be made to develop all aspects of the sports medicine series. Other series being considered include accident prevention and perhaps something on maternal welfare. The Board agreed that clinico-pathological series were perhaps overworked and *IMJ* would not go into this type of series at this time. A new look was to be taken at the most popular series, Medicine in the Out of Doors, published some five years ago. A series on accidents is to be developed.

In discussing the many papers being processed it was suggested that certain specific areas might get some

greater emphasis. In addition topics and authors were suggested for Medical Progress articles. These are to be followed through with invitations to individuals to submit items.

The Board reiterated its belief that articles of greater length than four pages in the *Journal* were possibly too long; the most desirable length would be four pages or less. In addition, symposia papers will be published according to established guidelines. (The Nutrition papers followed the procedure ideally during the past year.)

There is a need for good editorials in addition to those being prepared monthly by the editor. All members of the Editorial Board are encouraged to produce editorials and an invitation is extended to the general membership to insert items of interest and opinion in the Membership Forum section or in the Editorials.

Harvey Kravitz, *Chairman*

Charles Mueller Frederick Stenn
Charles Mrazek Arkell Vaughn
Frederick Steigman T. R. Van Dellen, *Editor*

Editor, *IMJ*

For the past several years it has been my distinct pleasure to report briefly on the content of the *Illinois Medical Journal*. During 1969, the *Journal* counted 1,510 pages, a slight decline from the 1,608 in 1968. This was due to a slightly lower amount of advertising. We maintain a 60/40 ratio; on this basis we had to cut back on some medical manuscript publishing.

During the year, 43 clinical articles appeared. These covered subjects in more than ten of the major specialties. Surgical Grand Rounds appeared 11 times and Medical Progress was carried nine times. In the latter, six major specialties were covered by the topics presented. In addition, 33 books were reviewed in the Doctor's Library, 23 editorials appeared and a number of special articles and features were carried. Of the total pages for the year, approximately 40% were devoted to clinical or clinically-related items and 20% was devoted to organizational items, excluding the pages allocated to the Convention and Reference issues. These percentages follow the guidelines established for internal balance. The average issue totaled 112 pages.

We have endeavored to maintain the *IMJ* as a truly educational publication, presenting items of current interest, and worthwhile to the practitioner. We have also attempted the inclusion of articles pertaining to most of the major specialties. In this manner, the *IMJ* will appeal to all members, not just those in a particular category.

Our staff has been engaged in maintaining good records of manuscripts and materials needed to produce a high-quality periodical. During the year we had occasion to make continued improvements in internal presentation styles and techniques, credit for which must go to the staff. Their continued cooperation is sincerely appreciated. I would also like to thank Dr. Leon Love, View Box editor, and Dr. John M. Beal, Surgical Grand Rounds editor, for their continued efforts and support of the *Journal*. These two fine gentlemen have continued their series over many months now as a labor of love and I must commend them for their fine contributions in our behalf. Without assistance such as theirs, the *IMJ* might be somewhat weaker in total content. Our capable managing editor, Richard A. Ott, and our advertising manager, John A. Kinney, also deserve a vote of thanks for their devotion to and work on the *IMJ*.

T. R. Van Dellen, *Editor*

COMMITTEE ON USUAL AND CUSTOMARY FEES

During the past year, the Usual and Customary Fee Committee concerned itself primarily with payments for physician services under the Illinois Department of Public Aid medical program.

The committee—which met with IDPA representatives three times during the past year—considered more than a dozen problems, most of which emanated from misunderstandings by physicians regarding IDPA payment policies.

The most controversial problem emanated from IDPA's policy of paying specialists at the same level of general practitioners. The committee learned that hospitals in high concentration welfare areas are finding it difficult to obtain adequate consultations by specialists because of the fee differential paid by IDPA. Since IDPA pays specialists at the level of general practitioners, specialists are reluctant to accept public aid patients.

To provide incentive to board eligible and board certified specialists to render increased care in medically deprived areas, the committee and the Board of Trustees approved a proposed IDPA pilot program to determine the feasibility of paying them their usual, customary and reasonable fee for a predetermined period of time.

The pilot program was proposed by Dr. Andrew Thomas, who attended the committee's November meeting on behalf of Chicago's black physicians.

While funds are available, IDPA reports that the project has not been implemented to date because Dr. Thomas has failed to provide the necessary information regarding the area involved, participating specialists and their usual and customary fees. As soon as this information is available, IDPA will initiate the program.

Since Medicare payments are currently being paid at approximately the 83rd per centile, and Medicaid payments are frozen in Illinois at approximately the 60th percentile of usual, customary and reasonable fees, the committee and Board of Trustees deplored this differential in allowable reasonable fees as defined by Medicare and Medicaid.

The committee was instrumental in having Dr. Jacob Reisch introduce a resolution into the AMA House of Delegates urging the AMA to request that Medicaid payments be increased to the Medicare level, but it was unanimously defeated.

The Rock Island County Medical Society requested guidance for physicians who wish to charge patients that portion of their fee not covered by the insurance company. The county medical society said it was advised that a court suit threatens local physicians who do so because of union contract provisions, which require industrial firms to pay for 100% of their health care.

The committee and Board of Trustees agree that a physician-patient relationship is such that the contractual agreement for reimbursement is between themselves. There is no contractual relationship present with any third party and therefore the patient is responsible to the physician for the payment of his fee.

The Rock Island County Medical Society also inquired whether it was ethical and feasible to recognize "higher customary fees for specialists than for general practitioners who do the same work."

The committee and Board of Trustees agree that—since there is no current fee schedule or relative value scale formally utilized by Illinois physicians—county medical societies should embrace the full range of fees of all physicians in the area as delineated by the usual, customary and reasonable definitions.

The committee requests House of Delegates approval of this recommendation.

Joseph R. O'Donnell, *Chairman*

Philip G. Thomsen

James B. Hartney

Mather Pfeiffenberger

Joseph L. Bordenave

Consultants

Jacob E. Reisch

George Shropshear

REFERENCE COMMITTEE MEETINGS

Sunday, May 17	7:00 p.m.
Officers and Administration	Holiday Room 105
Constitution and By-Laws	French Room 107
Finances, Budgets and Publications	Ruby Room 113
Legislation and Public Affairs	Old Chicago Room 101
Education and Community Health Services	Crystal Room
Economics and Social Services	Gold Room 114
Public Relations and Miscellaneous Business	Life Room 108

BOARD OF TRUSTEES MEETINGS

Saturday, May 16	2:00 p.m.	Crystal Room
Monday, May 18	8:00 a.m.	French Room 107
Tuesday, May 19	8:00 a.m.	French Room 107
Wednesday, May 20	8:00 a.m.	French Room 107
Wednesday, May 20	6:00 p.m.	Randolph Room

Economics & Governmental Health Programs

COUNCIL ON ECONOMICS AND GOVERNMENTAL HEALTH PROGRAMS

At the request of the Board of Trustees, the Council on Economics and Governmental Health Programs organized a state-wide peer review mechanism which it believes will be among the most effective in the country. Guidelines for the establishment and maintenance of state and local peer review committees were drafted by the Council and approved by Board members.

The guidelines were presented to county society leaders Feb. 8, at a Peer Review Seminar that highlighted the 1970 Leadership Conference. Judging from the excellent attendance and interest at the Conference, our membership is also aware of the importance of peer review.

The purpose and objectives for establishing statewide peer review include the following:

1. To protect the public from any physician who may be incompetent, corrupt or dishonest in his conduct.
2. To protect the physician against ill-founded and unjust accusations of patients and/or such agencies who may be interested in securing, or financing health services.
3. To accept complaints from all responsible sources.
4. To review such records and other pertinent information which may be presented to it for the purpose of recommending appropriate action.
5. To inform the public regarding the existence and functions of peer review committees.
6. To adopt formal written procedures and policies, with appropriate records to process complaints and to notify complainants about the disposition of their cases.

As described in the guidelines, a county medical society peer review committee would review all cases brought before it by physicians, patients, institutions, insurance carriers and governmental agencies. The committee would be concerned with the cost and quality of health care and act as an intermediary between the parties involved in disputes regarding fees, utilization, and patterns of practice.

The peer review committee is a positive approach to solving inadequacies and/or irregularities in providing quality health care. It is a vehicle whereby quality medical

care can be maintained within the framework of usual, customary and reasonable fees for a particular service in a respective geographic area. It will keep utilization of services and facilities consistent with accepted standards of practice and at an acceptable cost in an inflationary economy.

The local review mechanism is not a disciplinary body. It does, however, have an obligation to report its findings and make recommendations to other appropriate county or district committees requesting the latter take action when warranted by the circumstances.

The state peer review committee will be structured the same as county committees. It will function as an appellate body for cases brought before it from county or district committees. However, the state committee will also concern itself with irregularities in governmental or commercial health programs and bring them to the attention of other committees or the public via mass media.

Education will be a principal function of the state committee and it will disseminate the latest peer review information to all county committees.

Council suggestions for future activities include:

- 1) An annual meeting of all County Peer Review Committees that would be educationally beneficial to everyone;
- 2) The State Peer Review Committee should develop a liaison with county committees and offer such assistance as requested;
- 3) Relationships with all third party carriers including governmental health programs should be improved so that an atmosphere of mutual cooperation develops.

Fred Z. White, *Chairman*

Theodore Wachowski

Eli Borkon

Fred A. Tworoger

Robert C. Muehrcke

Rex O. McMorris

William E. Barnes

Charles E. Baldree, Jr.

Ralph Dolkart

Consultants

Joseph L. Bordenave

George Shropshire

J. Root, *SAMA Representative*

COMMITTEE ON PREPAYMENT PLANS AND ORGANIZATIONS

The Committee on Prepayment Plans and Organizations worked assiduously during the year to develop an effective peer review mechanism. In cooperation with the Council on Economics and Governmental Health Programs, peer review guidelines were prepared and approved by the Board of Trustees.

In carrying out the project, the committee chairman met with representatives from Medicare, Medicaid, Blue Cross-Blue Shield, the Illinois Department of Public Health, and the Health Insurance Council, to determine what each of these would require of peer review.

The committee asked the Council on Economics to consider the peer review question and assist in formulating guidelines. This has been accomplished.

This report is for information only and no action is required by the reference committee.

Theodore J. Wachowski, *Chairman*

Philip Lynch

Donald Casely

B. A. Kinsman

James P. FitzGibbons

Peter Starrett

Jacob E. Reisch, *Consultant*

Mike Youssi, *SAMA Representative*

MEDICAL ADVISORY COMMITTEE of the ILLINOIS DEPARTMENT OF PUBLIC AID

The Medical Advisory Committee of the Illinois Department of Public Aid met regularly during the year. At the ISMS Board of Trustees meeting, Oct. 12, 1969, the status of the committee was changed. Upon advice from the ISMS Legal Counsel, the Board decided that thereafter this committee should function as an official committee of the Illinois Department of Public Aid. It was felt this committee would better represent IDPA and therefore, should be responsible only to IDPA. ISMS staff assistance to the committee was discontinued.

Since the Medical Advisory Committee is no longer a committee of ISMS, is not funded by it nor produces materials requiring ISMS reference committee or House action, the committee will no longer submit a report to ISMS unless requested to do so. This will be the final committee report and is made only because of the committee's previous affiliation with ISMS.

Rex O. McMorris, *Chairman*

Sub-Committee on Drugs and Therapeutics

During the past year, the Sub-Committee on Drugs and Therapeutics met several times to refine the drug list contained in the Illinois Department of Public Aid "Drug Manual."

In order that the manual will reflect the prescribing habits of Illinois physicians, the committee spent many hours reviewing physicians' requests for drugs not listed in the manual. A complete and accurate record of requests and committee actions are kept in the society's office.

In 1969 the committee reviewed 1,917 written requests for drug usage.

The committee also reviewed numerous requests from pharmaceutical companies and has taken action at their request. Numerous drugs have been added. At the request of the committee the "Drug Manual" has been completely reviewed by the consultant to the committee and the Illinois Department of Public Aid. Changes in maximum amounts allowed were considered which will result in a savings to the Department.

Information currently available on drug reactions has been channeled to the committee at regular intervals.

The committee appreciates the cooperation it has received from the physicians as a whole. It welcomes their comments and will be guided by their sound therapeutic suggestions when making recommendations to the IDPA for future revisions of the "Drug Manual."

This is a report of information and no action is required by the reference committee.

Robert C. Muehrcke, *Chairman*

Joseph D. Cece

Richard L. Landau

Charles R. Frazer, Jr.

Kenneth Kessel

Louis Gdalmann, R.Ph., *Consultant*

ILLINOIS DEPARTMENT OF PUBLIC AID

The outlook for public aid programs for the forthcoming fiscal 1971 comes into clearer focus when viewed first from the perspective of trends over the past decade. (This article was written Feb. 5, 1970.)

Public aid rolls experienced two prolonged periods of increase and one of decrease during the 1960's. The decade opened with a three-year uptrend as persons of low education and marginal work skills lost their jobs during and in the wake of the economic recession of 1960 and 1961.

The uptrend was halted and then reversed beginning in mid-1962, the decline lasting through 1966. The drop came despite the fact that the rolls rose about 10% nationally. The decline in Illinois stemmed largely from the Department's emphasis on moving able-bodied adults, mainly unemployed fathers, into jobs, either directly from the aid rolls or following preparatory education and training.

The second upward trend in caseloads began in mid-1967, continued through 1968 and 1969, and is expected to carry through fiscal year 1971 (July 1, 1970 through June 30, 1971).

The monthly average of 546,000 on public aid during 1969 was 170,100, or 45.3% higher than the 1960 average of 375,000.

During the current uptrend (1967 through 1969), the monthly average rolls increased by 103,500. The yearly percentage increases were 8.8 in 1967, 11.5 in 1968, and 10.6 in 1969. Average monthly expenditures were \$29.6 million in 1967, \$37.8 million in 1968, and \$43.7 million in 1969.

From special studies and other experiences there emerges a number of conclusions why people are needy and why the caseloads are rising. Once the major causes of poverty were unemployment and economic depression. Spots of unemployment and occasional recessions still take their toll. But mainly when able-bodied adults are unemployed today, the reason is that lack of education and limited job skills keep them out of existing jobs. Manual and semi-skills have all but disappeared from the market. Surveys show that many adults in the Aid to Dependent Children program lack even an elementary education and many are illiterate. This means that most need some education and training to qualify for jobs in which they have had no previous work experience.

Realistically, the majority of the recipients are unemployables—the aged, blind, and the physically and mentally disabled—and minor children.

Education and training programs begun in the mid-1960's have moved thousands of fathers into employment and since, has limited cases headed by an unemployed father to about 3,000 families—cases closed and new cases opened tending to balance. The import now and for the foreseeable future is that the only sizeable group of adults with potential for employment is the ADC mothers. To realize the maximum of this work potential, more child care facilities must be established to enable mothers to work or to train for work.

The 276,250 children in ADC grant cases (December, 1969) are encouraged to get all the schooling possible, the minimum being a high school education.

Several factors, other than lack of education and skills, have contributed to rising caseloads. Desertion of the mother and children is an ever-increasing reason for application for ADC. Invalidation of the state's durational residency requirement (by federal court order in February, 1968) has since added some 7,000 new cases wherein residency in Illinois at the time of application was less than one year. And a recent U.S. District Court decision requires a hearing before assistance can be terminated or reduced.

Sustained inflation overcomes the low, fixed incomes of many people, particularly the aged and the handicapped. Population growth adds to the number of persons under age 16 and over 65, the age categories most vulnerable to dependency.

Major increases in caseloads stem from extensive news media coverage and the activities of community action groups which have greatly increased the public's knowledge of welfare programs. Thousands of eligible persons who formerly refrained from applying for assistance now do so.

To sum up the foregoing discussion, it is important to note that persons who receive public assistance do so because they have been determined, entitled to it in accordance with legislation and established standards. Their need developed from one or several factors extant in society itself, and quite outside IDPA's control. IDPA's responsibility, then, is to draw on all possible resources to rehabilitate the employables to self-support and to improve on the self-care potential of those whose stay on the rolls is indefinite.

Turning to the immediate future, IDPA expects to complete the remaining months of FY 70 without a deficiency appropriation. Distributive expenditures—those paid directly to recipients to cover food, shelter, etc., and those paid directly to vendors for goods and services, such as medical, rendered in behalf of recipients—account for a \$598.8 million appropriation for FY 70. Of this amount, \$233.8 million (39.0%) is for Medicaid; \$225.5 million (37.2%) is for ADC; \$72.5 million (12.1%) is for Assistance to the Aged, Blind or Disabled (AABD); \$56.0 million (9.3%) is for General Assistance (GA); \$13.0 million (2.2%) is for adult training and child care; and \$1.0 million (0.2%) is for all other distributive expenses.

As of this writing, IDPA's budget for FY 71 is not complete. Projecting needs through June 30, 1971, is a complex procedure because of the many variables involved. One must consider to what degree those pressures causing current rises will continue. Will undue inflation be curbed? Will there be a recession? What effect will new legislation have on welfare benefits, coverages, and eligibility requirements? (The President's welfare proposals are yet to be translated into programs by Congress.)

Special activities of interest to medical practitioners have taken place since the counterpart of this article in last year's *Handbook*.

The U.S. Department of Health, Education and Welfare requires certain quality reviews of the various persons who provide medical services and goods for public aid patients. In Illinois, peer professionals act as consultants for IDPA in the review of the performance of optometrists, physicians, dentists, and podiatrists.

Of interest to all who have direct concern with nutrition, the Food Stamp program in Illinois has been liberalized, effective March 1, 1970. Eligible public aid recipients and low income families not on public aid may pay less and yet receive more stamps than formerly, and have more food dollars in cash available.

Also, food allowances—which are tied to the consumer price index—were advanced 6% on January 1, 1970. This was the sixth increase for food resulting from changes in the consumer price index.

Regarding IDPA's payment of direct medical bills, there has been some improvement in billing procedures. Payments are machine-oriented so it is essential that in billing IDPA, the case identification information be precise and that the procedure performed be accurately coded—if IDPA is to fulfill its goal of paying all medical creditors promptly and accurately. All providers of medical goods and services are urged to strive for greater billing precision.

Significant improvements have been made in recent months in the mechanics of shifting aged patients from state mental hospitals to the communities. A better coordinated system is being worked out among interested agencies so as to smooth the flow of aged patients from state mental institutions to group care facilities and into community life.

Some important elements of the planning are:

1. The Department of Mental Health is responsible for clinical evaluation, physical preparation, and transportation of all patients to be released from state hospitals.
2. IDPA is responsible for determining the amounts to be paid for care in the new facility, based on the point schedule system which relates payments to the degree of care the individual requires.
3. The Department of Public Health is responsible for locating beds appropriate to placement and for licensing group care facilities.

Always in program planning, consideration is given to desirable new coverages and alternatives to current policy. Some of the considerations may be in anticipation of new federal legislation and some are suggested by individuals and groups with direct interest in health or welfare. However desirable many of the considerations are, their adoption depends on competition with all other governmental requirements and the availability of revenue.

Without suggesting that the following considerations will be adopted in FY 71, it is of interest to discuss a few proposals in the medical field.

IDPA's current level of involvement in preventive medicine is limited to paying for the physical examination and immunization of needy children at entry into the first, fifth and ninth grades of school. The Department of Public Health is responsible for seeing that governing legislation is followed. There are strong reasons for extending the examination and immunization programs to children from birth to entrance in school. Many physical and mental problems could be corrected or curtailed if treated early.

Payment for psychiatric services (outside mental hospitals) has been suggested as a desired improvement in IDPA's medical program.

Extension of "medical only" eligibility (for a limited time) to cases leaving the rolls might provide the necessary "bridge" from dependency to self-support. Similarly, the extension of family planning services (if requested) to mothers leaving the rolls would cut down the number of instances of a mother entering employment and then leaving it because of an unwanted pregnancy.

Also under study are procedural improvements in certifying persons eligible for medical or dental services.

Harold O. Swank, *Director*

ADVISORY COMMITTEE TO THE DIVISION OF VOCATIONAL REHABILITATION

During its first year of activity the Advisory Committee to the Division of Vocational Rehabilitation held two meetings with representatives from DVR. The Committee's

objectives were defined to primarily provide a channel of communication between ISMS and DVR and strive to foster mutual understanding and good relationships.

The Committee requested DVR to review and update its fee schedule so that usual, customary and reasonable fee concepts could be adopted. DVR agreed to give this serious consideration.

The Committee feels that its first year's activities have established the groundwork for a closer liaison with DVR and that the subjects discussed at future meetings will include a broad range of topics.

This report is submitted for information only and no action is required by the reference committee.

Eli Borkon, *Chairman*

Harry Grant
Harold A. Sofield
Joseph Compton
Thomas R. Glatter
A. Walter Wise

Thaddeus S. Pierce
Aaron M. Rosenthal
Brian H. Huncke
Frank J. Jirka, Jr.

ILLINOIS DIVISION OF VOCATIONAL REHABILITATION

Disabled persons in Illinois have available to them a government program that will help them with their disability and with the problems of preparing for and finding a job.

The program is called vocational rehabilitation. It is a partnership of the Federal Rehabilitation Services Administration and the State of Illinois. There is a vocational rehabilitation agency in every state, and in the District of Columbia, Puerto Rico, the Virgin Islands and Guam. Since the program was established in 1920, close to 2 million disabled persons in the United States have been prepared for and placed in almost all kinds of jobs.

How the Program Works

To give an idea of what it means to be "rehabilitated" for a job, here are some illustrations:

A man in Champaign County, recovering from a heart attack, is helped back on his feet by doctors, nurses, therapists, and others and provided with new work skills through training. He is trained for a job that does not put a strain on his heart, such as accounting. And he gets personal help in securing a job.

A woman in Chicago whose leg has been amputated is sent by her local rehabilitation office to a rehabilitation center, where she is given special medical treatment, fitted with an artificial leg, and trained in its use. Then she is tested for employment and prepared for a job in which an artificial leg is no great impediment—as a machine operator, for instance, or as an office worker. And she gets personal help in securing a job.

A mentally retarded man in Quincy is tested for all kinds of work he can do. On the basis of the tests, he is trained for an occupation within his capacity. And he gets personal help in securing a job.

These are only three instances of disabled persons who had capacity for employment. Other people—thousands of Illinoisans—have been helped in the same fashion and have overcome such disabilities as arthritis, blindness, orthopedic ailments, mental illness, heart trouble, deafness or hearing difficulties, speech impairments, stroke and epilepsy, among many others.

Disabled people, moreover, have landed almost any job you can name: construction worker, warehouseman, mechanic, cleaner and dyer, railroad brakeman, watchmaker, farm manager, trapper, cook, waiter, bookkeeper, clerk, salesman, civil engineer, physician, dentist, hotel manager,

among many others. In some cases, disabled housewives have been helped to learn better ways of managing a household.

Who is Eligible

How does a disabled person qualify for the program?

In general, the requirements are as follows:

The applicant must have a disability which prevents him from earning a living, or prevents his getting a job more suited to him, or threatens his continued employment.

The applicant must, in the judgment of the rehabilitation agency, have a reasonable chance of being able to work in suitable employment after services are provided.

Both men and women are eligible.

Where To Go

Where does a person go for these services? In Illinois, the Division of Vocational Rehabilitation accepts persons with any disability, including blindness.

The address of all vocational rehabilitation offices in the State of Illinois are available upon request from the State Office at 623 E. Adams St., Springfield. All of them have counselors who advise the disabled person and arrange for help with his disability and in preparing for a job.

Available Services

Medical Examination

To learn the nature and extent of disability, to help to determine whether the applicant is eligible, the need for additional medical services, and the disabled person's work capacities.

Medical Help

To restore or improve the disabled person's ability to do a job by providing medical, surgical, psychiatric or hospital services to remove or reduce the disability.

Physical Aids

These, where needed, include artificial limbs, braces, hearing devices, eyeglasses, and other aids.

Counseling and Guidance

A disabled person will be assigned to a trained rehabilitation counselor, who will give him specialized help in choosing the right kind of work and give him guidance until he is at work.

Training for the Proper Job

This may be provided in a trade school, in an institution of higher learning, in a rehabilitation center, or in on-the-job training.

Cost for Board, Room, Transportation, and Other Necessary Expenses

These may be provided, within certain limitations, while the disabled person is being prepared for work or is being helped to find a job.

Equipment and Licenses

Provided, if needed, to obtain the right job. Small business enterprises may also be set up if suitable as a vocation.

Placement in a Job

This amounts to assistance in finding the job.

Help on the Job

This is done to help the disabled person adjust to his new job—if he needs the help.

Vending Stand Program for the Blind

An important opportunity for employment of blind persons is offered by the Illinois Division of Vocational Rehabilitation's Vending Stand Program for the Blind. On sale at these stands are such commodities as tobacco, candy, confections and food items. Vending stand income compares favorably with that of most retailers.

An act of Congress provides for certain preference for blind people in the operation of vending stands in Federal buildings and grounds. However, about two-thirds of the stands are in non-Federal buildings and are established with the cooperation of the Illinois Division of Vocational Rehabilitation.

How to Obtain Vocational Rehabilitation

Contact DVR

A handicapped person goes to the DVR office in his area and explains his problem to a Vocational Rehabilitation Counselor. If this is not possible, contact can be made with the Counselor, and he will visit the handicapped person at his home.

Interview

The Counselor talks with the applicant in order to obtain necessary information about him and to arrange for medical examinations and vocational testing to determine what services are needed for satisfactory employment.

Diagnostic

The applicant receives complete medical examinations from his own physician to diagnose disability which interferes with employment and decide what treatment may be helpful.

Testing

A client is given various tests to determine what kind of work he can engage in most successfully.

Physical Restoration

If the handicap can be reduced by surgery, artificial appliance or other treatment, this is provided through their own doctor, to those who are unable to purchase their own.

Training

If training is required for a job most suitable for a client, this is also provided by the Illinois Division of Vocational Rehabilitation thru local trade schools, colleges, on-the-job training.

Placement

The Counselor makes every effort to place the client in remunerative employment. A special section of trained placement counselors assists in difficult cases.

EVERYBODY WINS

The fortunate thing about this whole vocational rehabilitation program is that everybody—the disabled and the non-disabled—benefits from it. For one thing, those who have no handicap that prevents them from working can take satisfaction in seeing disabled persons help themselves.

Everyone is ahead financially, too. A disabled person, instead of being supported by taxes his fellow Americans pay, is himself a taxpayer, once he goes to work. For every Federal dollar invested in his rehabilitation, in fact, he will return an average \$5 to the U.S. Treasury in Federal income taxes during the remainder of his working life.

But the most important person to benefit is the disabled person himself. Through this program, he has been enabled to live an independent, productive life.

Alfred Slicer, *Director*

VISIT YOUR EXHIBITS

Sherman House Hotel
Technical Exhibits—
Mezzanine Floor

HOURS

Monday, May 18—
11:00 a.m. to 5:00 p.m.

Tuesday, May 19—
9:00 a.m. to 5 p.m.

Wednesday, May 20—
9:00 a.m. to 5:00 p.m.

Education & Manpower

COUNCIL ON EDUCATION & MANPOWER

During the summer, the council had an interesting meeting at the University of Illinois, where council members had an opportunity to become acquainted with the executive faculty of the college of medicine, exchange information and learn about the college's expansion plans. Members of the council invited the faculty members to become more involved in medical society affairs, stating that a closer relationship could be mutually beneficial. A subcommittee of the combined group has been appointed to arrange another meeting and an agenda, which includes a look at committee structures of both college and society, to see where cross representation would be helpful.

The council also had an interesting and fruitful meeting with several members of the osteopathic profession. As a result of this meeting, the council recommends that it be permitted to establish an ad hoc committee to explore, with the osteopathic physicians, ways to eliminate the barriers to practice in the state, and to explore ways in which educational efforts and programs might be combined. Also the council should apprise the Board of Trustees of its findings as they relate to the physician shortage and health manpower needs in Illinois. It is understood that

the deliberations of this committee would be entirely apart from any other liaison committees working toward professional amalgamation or in any other area considered political.

With further regard to health manpower, the council received permission from the Board of Trustees to establish a new committee on Allied Health Education. This Committee, under the chairmanship of Dr. Eugene Johnson, has begun working toward establishment of a new category of physician assistants.

The Council is looking forward to the annual meeting of the State Medical Society, where it will present a program on Medical Education and its Relation to Community Health Needs.

Jack Gibbs, *Chairman*

Jeffrey Balfus, *SAMA*

Herschel L. Browns

Robert T. Fox

Norman Frank

Richard Landau

Richard M. Magraw

Morgan M. Meyer

Herman J. Nebel

R. Charles Oldfield, Jr.

Edward S. Petersen

William B. Rich

James M. Schless

James Shaffer

Donald Stehr

Robert J. Winter, *SAMA*

COMMITTEE ON CONTINUING EDUCATION

The Committee on Continuing Education held three meetings—one downstate and two upstate. The Committee recommended to the Council on Education and Manpower, and in turn, this council by official action recommended that:

1. *The Board of Trustees request the editor of the Illinois Medical Journal to revive "What Goes On In Illinois" as a regular feature of the publication;*
2. *The Board of Trustees instruct the committee on Scientific Assembly to schedule refresher courses for credit at the first annual meeting, where sufficient numbers of physicians can be expected to be staying in the convention hotel to provide an audience of appropriate size.*

The Committee developed and mailed early this year to each member of the ISMS, a record form for continuing medical education activities. This procedure was approved by the 1969 House of Delegates. A report of the data gathered will be developed for the next 1971 House of Delegates. In October of 1969, several members of the com-

mittee attended a workshop at the University of Illinois to gain information about the Regional Medical Program educational support resource center. The education support resource has received federal funds to provide professional assistance in planning, implementing and evaluating programs in continuing medical education in Illinois.

The educational support resource programs are directed to all health professions as well as paramedical educational programs. Dr. Cannady and Dr. George Miller, of the office on research and medical education at the University of Illinois, have discussed plans by which members of the ISMS could utilize the expertise of the educational resource support for the special benefit of physicians. Support for this program would exceed that available under RMP or University sources and an increase in dues to support this activity may be acceptable if the resultant programs can be viewed as necessary.

The Scientific Speakers Bureau, which is utilized regularly by about twenty county medical societies each year, continues to enjoy the financial support of Merck, Sharp

and Dohme. In addition to its annual grant, which pays the expenses and honoraria for physicians addressing county medical society meetings, Merck during the past year provided a supplementary contribution to finance a completely new edition of the Speakers Bureau Roster.

The committee recommended that ISMS officially express its gratitude to Merck, Sharp and Dohme, its Director of Professional Relations, Dr. Ralph E. Snyder, and its North Central Regional Manager, Mr. Joseph F. Head.

Herschel L. Browns, *Chairman*

William Bardsley	Theodore Z. Polley
James A. Felts	John Rathe
Leo R. Green	F. H. Riordan, III
Edward K. Griffiths	Robert J. Shafer
William F. Hubble	Herbert Sohn
Mays C. Maxwell	Gordon H. Sprague

COMMITTEE ON SCIENTIFIC ASSEMBLY

In accordance with instructions from the Board of Trustees, the committee has arranged the 1970 annual meeting program with the assistance and cooperation of various specialty societies in the state, but without using the traditional scientific sections that have been presenting programs not considered of general interest.

This year all the specialty societies were invited to cooperate in presenting general sessions while conducting their own business during luncheon meetings or at some other time. The committee has also attempted to prevent splintering of the annual meeting by discouraging any group wishing to present a program not considered of wide interest.

In this connection, it is recommended that committees and councils of the society be encouraged to publicize their activities by providing exhibits each year. The Committee on Scientific Assembly believes there is a real need for ISMS members to become acquainted with the work of the society as accomplished through its committees and it feels that this could be done more effectively through exhibits than through a formal program.

The committee has also taken a strong stand that attendance at the annual meeting will continue to drop until some other site is found. It should be noted that several technical exhibitors have stated they would not return until other accommodations are obtained.

Robert T. Fox, *Chairman*

Lee Fischer	J. Robert Thompson
Ira M. Rosenthal	Donald L. Unger

Elizabeth A. McGrew

Mrs. Paul Palmer, *Auxiliary Representative*

STUDENT LOAN FUND COMMITTEE

During the past year the Medical Student Loan Fund Board increased the amount available to students from \$1250 to \$1500 per year. New contracts have been drawn up for current participants to sign and will be available for all new participants in the summer.

Under a new contract effective January 1, 1970, penalty provisions are pro-rated and the program opened to students in all accredited medical schools, including out-of-state residents. Since the board is receiving increased interest from medical students in their junior and senior years, the following new policy has been adopted:

1. Students receiving a recommendation into the University of Illinois Medical School and/or receiving financial aid for a period of five years be required to serve five years in practice.
2. Students receiving financial aid only for a period of four years or less be required to practice for the same number of years that financial aid was received.
3. Students receiving financial aid for one semester will be required to provide a full year in practice with a minimum practice requirement of one year.

These new policies are spelled out in all official documents as well as in the new brochure, "He's an M.D.," thanks to help from the Illinois Medical Student Loan Fund Program.

Penalties for non-fulfillment of contract are \$3,000 for a student receiving a recommendation for admission to medical school and no loan, and \$1,000 per year for each year of the loan, plus 7% interest due on the money borrowed, for a student receiving a loan only or a recommendation and loan.

In return for assistance from the Medical Student Loan Fund Program, the recipient must agree to practice in an Illinois town serving a rural area. Minimum practice time is as follows:

- 1) Freshman student receiving a recommendation—five years.
- 2) Freshman student requesting loan assistance for five years—five years.
- 3) Upper classman already in medical school—one year of practice for each year that financial aid is taken. (one year minimum)

On November 7, 1969, the committee hosted its present medical school students and their wives at the annual dinner meeting. Dr. Eugene Johnson, of Casey, was the principal speaker. He described the medical care plan which has been developed in Clark County where there are only four physicians.

On January 28-29, the joint ISMS—Illinois Agricultural Association Committee met in Bloomington to conduct its annual business meeting and to interview candidates seeking recommendation for admission to the University of Illinois College of Medicine.

A total of 33 candidates were interviewed. Ten were recommended for admission to the University of Illinois. All were subsequently accepted by the University. An additional candidate, who was recommended separately, was not accepted. Of these, two sought recommendation only; the others will apply for loans. Five students were rejected with an invitation to re-apply.

A resolution urging the University to "double the allocation of places for applicants that have previously been made available to this program . . ." was adopted by the Board, but deferred until such time as more qualified applicants are available.

Loan Fund Financial Status

The total value of the Student Loan Fund at December 31, 1969, was \$243,747 (owned 50/50 by ISMS and the Illinois Agricultural Association). The assets of the fund at that date, compared with the preceding year, were:

12/31/69		01/08/69
\$ 85,000	U.S. Treasury Bills	\$ 85,000
146,041	2% Student Promissory Notes	138,166
8,406	Cash	6,650
4,300	Liquidating penalties due	4,550
<u>\$243,747</u>		<u>\$234,366</u>

The fund's annual income report for the past three years is as follows:

	1969	1968	1967
Receipts:			
2% interest	\$3,226	\$1,307	\$3,601
Treasury bill interest	5,158	3,591	5,190
	<u>\$8,384</u>	<u>\$4,898</u>	<u>\$8,791</u>
Expenses:			
Trust administration fee	1,569	1,417	1,360
Net income	<u>\$6,815</u>	<u>\$3,481</u>	<u>\$7,431</u>

Donald Stehr, *Chairman*

Jack Gibbs

Charles Salesman

Jacob E. Reisch, *Consultant*

ADVISORY COMMITTEE TO THE STUDENT AMERICAN MEDICAL ASSOCIATION

The Advisory Committee to SAMA is proud that the summer job-education project it launched in 1969 was considered almost 100 per cent successful. Although the final report on the project attests to its effectiveness, the most satisfying measurement of success has been the expansion of the program for 1970. Participating hospitals and students will be double the number involved in 1969.

The committee is concerned, however, that some of the important goals of this program, including retention of doctors in Illinois, will not be achieved if proper provision is not made for follow-up—evaluation of the program and continued contact with its participants.

The committee recommends that ISMS provide funds for adequate debriefing of participants through a workshop each fall and that continued contact be kept with participants. The project is growing, it involves more people and more hospitals than it did originally and should not be expected to operate on less money than it did last year. Since the program is still in the development stage, it needs further evaluation and refining, in order to serve as a model for a national program to be financed next year by the Sears Foundation. The program is important to ISMS, because it introduces students to the clinical practice of medicine in their early years before they become committed to another career. Therefore, the committee believes the society has an obligation to provide for adequate followup.

In addition to the summer program now known as MECO, Medical Education and Community Orientation, the Advisory Committee has been involved in these additional areas:

Implementation of *Resolutions 69M-26, 69M-29 and 69M-34*, all of which involve financial aid and manpower. During the year the committee became acutely aware of financial problems faced by medical students because of inflation and the cutback in the federal loan program. After meeting with financial aid officers of the various medical schools to confirm that a crisis did exist, the committee received permission from the Board of Trustees to solicit individual ISMS members for contributions to the Educational and Scientific Foundation to be used to help students. Before the solicitation could be made on a state-wide basis, however, information was received through the AMA and medical school deans, that the immediate crisis had passed and that forces were at work to solve the long range problem.

Letters were sent, over President Cannady's signature, to all Illinois senators and congressmen urging that funds be restored to the federal loan program, and county medical societies were encouraged to establish their own scholarship-loan programs.

The committee is now recommending that ISMS go on record favoring federal subsidies to pay the interest on AMA-ERF loan funds, which are legally tied to current high interest rates that medical students find discouraging. The committee suggests that ISMS use its legislative contacts as well as the AMA to obtain these subsidies.

The committee has also discussed ISMS membership for medical students and recommends that, instead of changing the ISMS Constitution and Bylaws and placing several thousand medical students, interns and residents on the society mailing list, the society work through existing organizations. It is, therefore, recommended that:

The Illinois Medical Journal and such other publications and official correspondence as ISMS sends to all its members, be mailed to members of SAMA in Illinois, whose names and addresses are available through the AMA.

It is further recommended that the Illinois State Medical Society take positive steps to establish liaison with interns and residents in Illinois through house staff organizations in appropriate hospitals.

The above action has not been approved by the Council on Education and Manpower.

At the Committee's instigation, students were appointed members of most ISMS councils and committees and are reported to be taking an active interest and contributing to the work of the committees.

Student members of the Advisory Committee believe that such opportunity to participate in society affairs is much more valuable than holding membership in the society and voting in the House of Delegates.

At the same time, the students believe that communication is a two-way street and SAMA encourages physicians to become sustaining members of their organization.

During the past year ISMS became one of several state medical societies paying the expenses of students attending AMA meetings. The advisory committee believes that contact between physicians and students as individuals and through county societies is mutually advantageous to ISMS and the AMA. In an effort to provide individual contact, the committee has arranged for students to spend weekends with doctors in their homes and would like to encourage more visitations of this kind.

Norman M. Frank, *Chairman*

Louis Bernstein, *SAMA*

Allison L. Burdick, Jr.

T. Howard Clarke

N. Kenneth Furlong

Jerry Ingalls

Courtney P. Jones

Louis Limarzi

Phillip E. Mac

Larry Stone, *SAMA*

Kong-Meng Tan, *SAMA*

Nathan Iglitzen

Mrs. Mitchell Spellberg, *Auxiliary Representative*

COMMITTEE ON ALLIED HEALTH EDUCATION

This committee was established late in the year to fulfill the following responsibilities and purposes:

As a means to alleviate the effects of a physician shortage that exists in virtually all parts of Illinois, it has been suggested that allied health personnel be educated and trained to perform certain medical procedures heretofore done only by physicians. This committee should be concerned with the specific types of medical procedures which could be done readily by trained non-physicians and what education and training is needed to qualify such individuals as "assistant physicians." The committee necessarily will concern itself with the legality of this activity under the Illinois Medical Practice Act, the implications of licensure and relations with the Illinois Department of Registration and Education, and liaison with medical schools and other educational institutions established for training of the personnel involved.

In its initial meeting, the committee decided to work for establishment of a category of health personnel, who would be educated through a step ladder system that would allow individuals to proceed to the status of physician or stop at a level of competence and proficiency that might be classified as a physician's assistant.

Eugene P. Johnson, *Chairman*

James D. Eggers, Jr.

Lawrence L. Hirsch

Donald E. Rager

Sheldon S. Waldstein

Richard M. Magraw
Consultants

Israel Light

Donald Frey

Environmental & Community Health

COUNCIL ON ENVIRONMENTAL & COMMUNITY HEALTH

The Council on Environmental & Community Health, as its name implies, concerns itself with such broad areas as water, air and noise pollution and such public health matters as radiation protection and industrial hygiene, but it also covers the work of the following standing committees, whose individual reports appear below:

- Child Health
- Maternal Welfare
- Nutrition
- Public Safety

During the year the council endorsed the statement, "Let's Talk Sense About Sex Education," prepared by representatives of a group of responsible organizations in Chicago spearheaded by the Association for Family Living; encouraged the Nutrition Committee to develop a position statement on hunger and malnutrition; and recommended that ISMS contribute \$100 to support the Interagency Council on Smoking and Disease. Dr. Kenneth Nolan, of the Child Health Committee, was subsequently appointed official ISMS representative to this council.

The Council also recommended that ISMS assume leader-

ship in supporting state immunization laws, enlist cooperation of the PTA in an educational campaign to encourage compliance with the law, and lend its efforts to increasing the supply of vaccine (particularly Rubella) in Illinois.

In addition the Council supported the Maternal Welfare Committee's recommendation on uniform pregnancy leaves—six weeks prior to and six weeks after delivery.

A decision was made to confine participation in pollution control activities to medical aspects and avoid political and socio-economic areas. In this connection the chairman was authorized by the Board of Trustees to attend a Great Lakes Conference sponsored by the Toronto Medical Association. A follow-up meeting may be recommended for Chicago in June.

Edward A. Piszczek, *Chairman*

Howard C. Burkhead, *Co-Chairman*

James P. Campbell
Eugene F. Diamond
Clifton Hall
Robert R. Hartman
John S. Hyde
Ralph H. Kunstadter

David F. Lowen
Robert J. Maganini
Richard M. Pope
Tony Proske
Arthur E. Sulek
James S. Whitehouse

COMMITTEE ON CHILD HEALTH

Because it is in childhood and adolescence that drug experimentation begins, the Child Health Committee feels obligated to become as knowledgeable as possible about this problem. It has reviewed various educational materials on the subject of drug abuse and recommends:

That the Illinois State Medical Society strongly oppose Legalizing marijuana, which should not be equated with alcohol and tobacco, and that further education on drug abuse be implemented.

The committee also recommends that Illinois physicians be encouraged to distribute drug abuse literature through their offices and local schools and that a physician be present for consultation, if possible, when drug abuse films are shown in the community.

The chairman has met with the ISMS Nutrition Committee and helped develop new recommendations regarding IDPA food allowances.

The committee has also been interested in the subject of sex education and it recommends:

That the Illinois State Medical Society urge that medical schools in Illinois include sex education as a part

of the medical school curriculum.

The committee has studied the recommendations of the Illinois Joint Committee on School Health regarding the mandatory teaching of health education in the school and expects to take an official position on any legislation developed in this area.

Two other continuing problems concern the committee. First, the committee believes that the public and the medical profession have become complacent about immunizations. Periodic outbreaks of preventable diseases prove that physicians should be continually reminded of the need to initiate and keep up immunizations as recommended by the Illinois Department of Public Health. Greater efforts should be made by public health departments to reach and immunize the indigent comprising the greatest number of the unprotected.

The other concern is that laws requiring health examination for children entering first, fifth and ninth grades are frequently not being enforced. It is therefore recommended:

That the Illinois State Medical Society urge the Chicago Board of Education and all school districts

in the state provide sufficient money in their 1970 and subsequent budgets to employ whatever number of doctors and other health professionals as are required to carry out indicated school health procedures in compliance with state law.

Ralph H. Kunststadter, *Chairman*

Irving Abrams	Edward F. Lis
Patricia Dix	J. Keller Mack
Richard E. Dukes	Franklin A. Munsey
W. W. Fullerton	Kenneth S. Nolan
Edmond R. Hess	T. A. Palus
Edward Jung	Norman T. Welford

COMMITTEE ON MATERNAL WELFARE

The Maternal Welfare Committee has conducted three meetings since the chairman presented his report at the last annual meeting. There continues to be some difficulty in the completion of protocols. At the time of this writing, March 1, 1970, there are known to be at least seven incomplete or unaudited death reports. It is felt that to a great extent this is due to the difficulties being experienced by the Illinois Department of Public Health in securing a full-time consultant in the field of obstetrics and gynecology. Your chairman is cognizant, however, of the difficulties the department is having; particularly in that the ideal person for this job should be not only a specialist in the field of obstetrics and gynecology, but also have special training in public health. Such people are not only difficult to find, but their scarcity puts a high monetary value on their services. Continuing efforts between your chairman and the Department of Public Health to solve this problem are being exerted.

At the time of this report 47 1969 cases have been coded. Of these, 26 were classified as being directly obstetrical. The largest category is in the field of hemorrhage which accounted for 9 deaths. Only one of these was due to an ectopic pregnancy, 2 to abruptio placenta, 7 to ruptured uteri, and one to uterine atony. We feel fortunate that so far only 3 deaths have been assigned to toxemia—one a severe pre-eclampsia, one atypical eclampsia, and the third one, toxemia superimposed upon a chronic hypertensive cardiovascular disease. Infection continues to plague us. Seven deaths occurred from this cause; 5 of which were thought to be directly attributable to criminal abortions. Vascular accidents accounted for only 2 deaths—one due to amniotic fluid embolism and the second due to a puerperal nonseptic pulmonary embolism. Anesthesia was responsible for 5 deaths—one of which was due to aspiration asphyxia and 4 due to cardiac arrests probably involving failure of the anesthetist to maintain a good airway and/or good oxygenation. Anesthetic deaths are always classified as being preventable, and each of us should remember that a patient comes to the hospital not to receive an anesthetic but to be delivered of a live baby in the safest possible way.

There were 11 instances in which an obstetrical situation was thought to have contributed to the worsening of a pre-existing disease and thus causing death. One death was recorded from rheumatic heart disease, 3 from pulmonary emboli, 3 from pneumonia—one a lobular pneumonia and two cases of atypical pneumonia. Only one diabetic was lost throughout the year. Two patients died of ruptured berry aneurysms which your committee has elected to be coded as being aggravated by pregnancy. There were 10 deaths which occurred to women, who were pregnant, which were thought to be in no way related to the pregnancy.

The committee continues to find a large number of preventable factors. There was one case in which the patient, the doctor and the hospital were all thought to be involved in the tragic demise, 7 cases in which the patient and the doctor were thought to share some responsibility for the death, and a total of fourteen cases in which the patient's failure to cooperate or exercise good judgment were cited as precipitating factors. Sixteen instances of medical errors of omission and commission were thought to exist.

In conclusion, preventable maternal deaths are still occurring in our state. It is the hope of your chairman that the work of this committee can be made more meaningful by a wider dissemination of the knowledge gained from its deliberations. Your chairman would be totally remiss if it did not express his appreciation to all the members of the committee for their wisdom, patience and advice in studying these troublesome cases. The contribution of Dr. Szanto on those occasions when he has been able to present pathological findings to us, Dr. Webster and her staff, representing an educational hospital with its contact with new and evolving therapy, and the opinions of Dr. John Louis in the field of hematology have contributed to our joint enlightenment. Your chairman feels that his service on this committee is the most rewarding and educational experience of his professional life.

Robert R. Hartman, *Chairman*

V. B. Adams	Hubert Magill
Gordon T. Burns	Robert Maletich
William W. Curtis	W. R. Malony
William J. Farley	John C. Mason, Jr.
Frederick H. Falls	John J. McLaughlin
Donald M. Gallagher	John R. Powell
Ralph Gibson	Paul A. Raber
Melvin Goodman	Donald R. Risley
Charles F. Kramer	Roger P. Smith
William R. Larsen	James B. Stotlar
Harry L. Lewis	Charles P. Westfall

Richard Yoder
Consultants

John Louis	Willard C. Scrivner
Donaldson F. Rawlings	Augusta Webster
Franklin D. Yoder	

NUTRITION COMMITTEE

The Chairman attended the Conference on Nutrition in Medicine at Eastern Illinois University in Charleston on October 3, 1969. The ISMS co-sponsored the conference with the Illinois Nutrition Committee and the Illinois Department of Public Health. The Chairman addressed the conference on behalf of the society and also spoke at the luncheon of the Illinois Nutrition Committee. Highlights of the conference were reports on the study on the Nutritional Status of Pre-School Children by Dr. George Owen of Ohio State University and a report on the National Nutrition Survey, by Dr. Ogden Johnson of the U.S. Public Health Service.

White House Conference

The Chairman was the representative of the ISMS to the White House Conference on Food, Nutrition and Health from November 30-December 4, 1969.

The following were the principal proposals made by the Conference to the President:

- a) That the President declare a national hunger emergency.
- b) That a free school lunch and breakfast program be made available immediately to all school children, through secondary school and regardless of income. This program would provide at least two-thirds of the Recommended Dietary Allowance, while respecting cultural food preferences.
- c) Hospitals and other medical care centers should pay greater attention to the nutritional care of all patients. The medical profession should make nutritional care an integral part of total medical service.
- d) Federal government should provide financial support for the establishment of high-level nutrition teaching and research centers in every state.
- e) A national code of uniform health, nutrition, and personnel standards should be established for facilities that care for the aged.
- f) Departments of Transportation and HEW should seek ways to transport the elderly to health, nutrition and other social services.
- g) Government and industry should work to develop food products that will satisfy the special requirements of the elderly.
- h) A National Institute of Nutrition and Food Sciences should be established to coordinate the food science expertise available throughout the Federal Government.
- i) Improvement of detection and investigation of food-borne diseases.
- j) Action should be taken immediately to fortify at least the following foods in common use: bread, protein-fortified teething biscuits, flour and cornmeal, rice, processed meat products, citrus and soft drinks.
- k) Education of mothers and the general public on the advantages of breast feeding.
- l) Comprehensive health care for pregnant teenagers including provisions for continuing schooling.
- m) Guaranteed annual income of \$5200 for a family of 4.

President's message—important points:

- 1) Declared an urgent national committee to put an end to hunger and malnutrition due to poverty in America.
- 2) We don't know just how many Americans are actually hungry and how many suffer from malnutrition but we do know that there are too many Americans in both categories.
- 3) Directed Agricultural Secretary Hardin to extend food stamp programs to the more than 300 counties that have no federal food programs. Also asked Secretary Hardin to extend the maximum family food stamp allotment from \$65.00 to \$106.00 for a family of 4.

The Nutrition Committee met on November 17, 1969, and February 26, 1970. Invited guests were Dr. Ralph Kunstadter, chairman of the Child Health Committee, Dr. Daniel Pachman, president of the Illinois Chapter of the American Academy of Pediatrics, Dr. Phillip White of the AMA Council on Food and Nutrition, Dr. Paul Tracy representing the Chicago Pediatric Society, Dr. Louise Majonnier of the Chicago Board of Health, Dr. Hilda White, Northwestern University School of Home Economics and Mrs. Betty Taif of the Chicago Board of Health. Dr. J. Ernest Breed, president-elect of

ISMS. Drs. Diamond and Filek and Mr. Smithers appeared for the committee.

A very valuable discussion and exchange was carried out concerning the Illinois Department of Public Aid Food Budget. All participants contributed generously, each from his particular expertise regarding this complex problem. The following is the proposal developed from these meetings.

Nutrition Committee Recommendations Regarding the IDPA Food Allowance

Accurate statistics on the extent of hunger and malnutrition in the State of Illinois are not available. National figures will be available with the completion of the National Nutrition Survey (which does not include Illinois) and the Study of Pediatric Nutrition by Dr. George Owen, which does include a limited Illinois sample. Whatever the statistics, hunger and malnutrition are intolerable in an affluent society. Hunger is basically a social problem demanding sweeping social solutions of the type suggested by the Nixon administration to include income maintenance and/or family allowance. Malnutrition is a medical problem which is of particular concern among children, pregnant women, and senior citizens who are isolated and incapable of self-sufficiency. There seems little doubt that the improved nutrition of pregnant women and of infants could significantly reduce perinatal and infant morbidity. No amount of money will correct malnutrition unless its expenditure is accompanied by a program of education. Nutrition education should begin in the school system. Mass media including television and ethnic radio stations should include nutrition education as a public service. The individual welfare family should be educated through home management courses and home advisers drawn from the same ethnic background, who can give direct indoctrination and assistance.

The major supplementary food programs would all seem to be underutilized in the State of Illinois and these should be expanded to take advantage of currently available federal funds. Full implementation of the commodity distribution program, the food stamp program, and the school lunch program would make more food available to those in need. Various administrative problems have contributed, to a degree, in the failure of full participation by welfare participants in some of these programs. Participation in the food stamp program in Chicago, for example, is discouraged by 1) the need to purchase stamps from currency exchanges rather than receiving them directly 2) the need for cumbersome recertification procedures. 3) high purchase requirements (70% of food budget) 4) restriction of food stamp purchase to food with exclusion to household essentials. Only 30% of IDPA families now participate in the food stamp program. One contributory factor is the need to use the food budget money to meet other fixed expenses such as clothing, rent, and utilities. This "raiding" of the vulnerable food allowance makes it difficult to discuss food allowances outside the context of the total living allowance.

Much effort has been made through the years to price budget standards fairly. Food budget allowances have been reduced in their purchasing power by various factors: 1) food prices are higher in poverty areas because of the need to raise prices to maintain profit margins

in face of pilfering, high insurance premiums and other contingencies associated with storekeeping in the center city as contrasted with outlying or suburban areas; 2) food cannot be purchased in quantity or in economical large packages because of inadequate storage facilities and limited refrigeration in welfare homes; 3) limited management and shopping skills and the need for education on the part of the homemaker; 4) the reduced buying power of the budget in the face of rapid inflationary trends; 5) the failure of food budgets to allow for such secondary food needs as variety, convenience, and the social aspects of sharing food.

A revision of the Food Stamp Program in Illinois was finalized on January 16, 1970. Major changes include: 1) lowering the purchase requirement to 59-65% for households of 1-8 persons with additional modifications of 9 or more; 2) increasing individual bonus stamps from \$4-\$6 to about \$10-\$12; 3) increasing the maximum net income for eligibility in non-assistance families, thereby increasing the number of persons eligible for participation. The food stamp plan is available in all Illinois counties.

The National Research Council published recommendations in 1963 and 1968. The U.S. Department of Agriculture published a revised food plan in October, 1964, using the 1963 NRC recommendations as the principal criterion of nutritional adequacy. No food plan has been developed by the USDA to fulfill the 1968 NRC recommendations up to this time. The current IDPA food standard does not provide the amount of iron recommended in 1968 by the NRC for children under 6 and girls 9 through 12 years. The IDPA food allowances were computed from prices collected statewide in April, 1963, and averaged. Price adjustments have been made since 1963 according to fluctuations in the Bureau of Labor Statistics Index for food at home in Chicago. As of January 1, 1970, the allowances have been increased 21% in 6 years.

Comparison of the monthly IDPA food allowance on 1/1/70 and the U.S.D.A. Low Cost Plan, U.S. average as of September, 1969, reveals the following:

Family Composition	IDPA	Differences IDPA & USDA Low Cost Plan	
		USDA Low Cost Plan	USDA Low Cost Plan
Child 13 to 20 yrs.	\$28.53	\$38.00	-\$9.47
Child 6 to 12 yrs.	22.75	30.70	- 7.95
Child Infant to 5 yrs.	16.16	20.30	- 4.14
ADC Adult	25.16	33.70	- 8.54
Total	\$92.60	\$122.70	-\$30.10

SUMMARY

The Nutrition Committee recommends that the following measures be undertaken to make more food available to welfare recipients:

- 1. The IDPA food allowance should be increased to conform with the USDA Low Cost Plan.
- 2. Every effort should be made to expand and implement all supplementary food programs in Illinois including the food stamp program, the school lunch program and the supplementary foods program.
- 3. Food allowances should be adjusted in the future for increases in the Bureau of Labor Statistics Price Index with reevaluations every 3 months and budgeting in-

for April, 1970

creases fully commensurate with the increase in the costs of living.

- 4. Other items of the IDPA budget should be revised and repriced regularly to make them current and decrease pressure on the food budget.
- 5. Consumer education should be further implemented and expanded by the most efficient media or method available.
- 6. Clearing house for nutrition information should be established at a State level with the responsibility of accumulating and disseminating professional nutrition materials and data.

Eugene F. Diamond, Chairman
Teresa Berry
Allan A. Filek
Paul A. Dailey, Consultant

COMMITTEE ON PUBLIC SAFETY

The Committee has been interested in implied consent legislation, which thus far has failed to pass the Illinois General Assembly, and expects to meet jointly with the ISMS Alcoholism Committee to discuss the subject before the next session of the legislature.

The committee endorsed the principle of a medical emergency commission and expects to cooperate with the new commission now being organized.

A new area of concern to the committee is the effect that certain antihistamines and other over-the-counter drugs may have on driving. The committee expects to go into the subject more deeply during the coming year.

The committee is also concerned about the lack of medical supervision in school athletics and it recommends that:

School sponsored athletic teams, both in practice sessions and in competitive games, should be attended by a licensed physician. Since injuries are not infrequent in baseball, wrestling, and other sports, in addition to such contact sports as football, they are included in this recommendation, which should not be compromised because it cannot be enforced in 100% of the cases.

James P. Campbell, Chairman
Edward W. Holmblad
Julius M. Kowalski
Robert R. Luther
Norman J. Rose
William J. Schnute
Clifford P. Sullivan
Mrs. Arthur A. Smith, Auxiliary Representative

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

The following is an abbreviated report on the programs and activities of the Illinois Department of Public Health. Employing approximately 1,300 professional, administrative, technical and clerical workers, the department is charged with the responsibility of leadership in the protection and promotion of the health of all of the people.

Electronic Data Processing

The Bureau of Data Processing functions as a service agency to all divisions and bureaus of the department by providing statistical reports on health information important to planning, organizing, directing, controlling and coordinating program activities.

In 1968, steps were taken toward the creation of a long-range Total Health Information System. The THIS program is designed to centralize computer-based health information so that we might arrive at an improved

allocation of both private and public resources to service existing needs.

THIS has been developed through the following planned sequence:

Phase I—Development of the integrated **THIS**

concept

Phase II—Systems Design

Phase III—Programming and Implementation

Phase I was completed in March, 1969. Phase II, now underway, is scheduled for completion in mid-1970. The eventual establishment of a single computer-based health information system will permit integration of vital statistics, public and private health resource information, and status and need data, including air and water pollution data. The **THIS** Data Bank will be available to the system's users as a management tool to effect a "partnership for health" approach in effective comprehensive health planning.

Nursing

The Bureau of Nursing gives consultative and advisory service to all public health nurses in the state including those employed by the department, those employed in schools and industries, and those employed in city, county, and regional health departments and private agencies. It also is responsible for recruiting, training, and placing of nurses; for continuous staff education; for developing sound professional standards; and for promoting leadership in the profession.

Health Education

Health education is that process whereby people are induced to alter or change their health habits and behavior. The bureau has the mission of providing public health workers at the state and local level with those educational and informational services best calculated to facilitate the understanding, acceptance and use among the population of the most up-to-date scientific information about health.

Community Health Resources

The purpose of the Community Health Resources Program is to assist economically disadvantaged communities in the planning, development, and expansion of programs aimed at improving health services. A multi-disciplinary team of health professionals is available for consultation and technical assistance to community groups, local health departments and other agencies concerned with the health problems of the disadvantaged.

Preventive Medicine

This division administers a program for the care of premature infants; the PKU screening program; a family planning program; a program of limited health services for migrants; three major services in the areas of hearing conservation, including audiometric screening, otologic-diagnostic clinics and training; a vision screening program with increased emphasis on finding Amblyopia Ex Anopsia through mass screening programs; programs for prevention and control of communicable diseases; and an expanded venereal disease control program.

Rules and regulations on immunization have been issued by the department, as directed by the first compulsory immunization law in Illinois, which was enacted in July, 1967.

The department's section on traffic safety includes certification of clinicians and technicians engaged in blood

alcohol testing, and setting standards and developing courses of study for operators of breath analyzing devices. The Blood Alcohol Project, a joint responsibility between the department and the coroners of the state, is being continued.

The division has established 99 poison control centers in Illinois and directs their activities in accordance with the standards developed by the American Association of Poison Control Centers.

Sanitary Engineering

Surface water quality standards were revised to meet requests of the U. S. Department of the Interior. Due to variations in quantity and usage of streams, eight separate standards were developed. Major efforts will continue to be directed toward the expansion, improvement, and efficient operation of sewage treatment works in order to upgrade stream water quality or maintain present high quality waters. The Bureau of Stream Pollution Control provides the technical staff for the state Sanitary Water Board.

In addition, efficient administration of the Public Water Supply Control Law and the Swimming Pool Law assures that adequate public water supplies and safe swimming facilities will be available to the citizens of the state.

The Bureau of Air Pollution Control provides the technical staff for the Illinois Air Pollution Control Board, and administers the inspection of air pollution violations and follow-up enforcement in order to prevent, abate and control air pollution throughout the state as provided in the statewide air pollution control law.

The radiological health program has the overall objective of assuring that sources of ionizing radiation are used safely. In accordance with the provisions of the Radiation Monitoring Act, and the regulations which have developed, the department is maintaining records on occupational external radiation exposure for employees receiving exposure to ionizing radiation in Illinois. The Act also provides the department with the authority to approve film badge monitoring services.

The division administers the Laser System Registration Law which requires registration of laser systems and reporting of accidental injuries.

On Dec. 19, 1969, rules and regulations were established which banned the sale and use of DDT in Illinois except by permit, issued only by the directors of the Department of Agriculture and the Department of Public Health.

The state's solid waste disposal program, trailer park regulations, migrant labor camp inspection and vector control programs are administered by the division's Bureau of General Sanitation.

Health Care Facilities and Chronic Illness

This division administers the heart, rheumatic fever, cancer, glaucoma and diabetes programs, and provides consultation in the field of nutrition for the division and the department.

The division established a Chronic Renal Disease Program to provide help to Illinois residents who suffer chronic renal failure. One million dollars was appropriated by the 75th General Assembly to implement the program over a two-year period.

The division also plans, directs, and implements the Rehabilitation Education Service program throughout the state; administers the Hill-Burton program and the Packaged Disaster Hospital program; provides professional

expertise to the department in medical specialties and other scientific fields; administers the state licensing program for hospitals, independent laboratories and long-term care facilities as well as the Medicare certification program for hospitals, extended care facilities, independent laboratories, and home health agencies; and is responsible for compiling vital data for the preparation of cost studies.

Local Health Services

The major responsibility of this division concerns the functioning of 48 autonomous county and multiple-county health departments, ten city and local district health departments, and the seven regional offices of the division. It serves in a liaison capacity for the department's program directors, the regional offices, and the local health departments, assisting in their implementation of Illinois Public Health Laws and Rules and Regulations through counseling and by providing channels of communications.

The division has the responsibility for administering standards related to programs, performance, and qualifications of personnel in local health departments.

Dental Health

In addition to the implementation and surveillance of the fluoridation legislation, the Division of Dental Health is currently involved in 10 other program areas. The primary emphasis is on education at all levels and prevention through various types of topical fluoride programs.

Care, on a limited basis, is provided to indigent and migrant children throughout the state by means of a self-contained two-chair mobile clinic.

A large portion of time is devoted to consulting work. Dentists or dental hygienists are available to assist local, state, or federal agencies in the development of dental programs.

An approved residency program in Dental Public Health is also conducted by the division.

Health Planning and Resource Development

The activities of the division continue to be directed toward the formulation of plans, policies, and procedures for the implementation of P.L. 89-749 and its amendments contained in P.L. 90-174. Local communities are encouraged to organize for planning aimed at solving particular local health problems. The division's functions include the gathering of information regarding programs and activities of all of the voluntary and official, public and private, medical, dental, nursing, and other health related personnel, resources, and facilities; collating, recording and studying them; and making recommendations to establish priorities among existing activities, encouraging new activities if needed and eliminating unnecessary duplication.

Food and Drugs

Surveillance of food and drug manufacturing, and processing and packaging plants is being intensified in Illinois under the federal-state partnership. Laboratory testing for pesticide residues of all foods and foodborne pathogenic micro-organisms in ready-to-eat foods also has been intensified. Test results indicate that 11% of all samples tested are violative for microbiological assay, 8.3% of meat samples are violative for additives, 16.67% drug samples are violative and 24% of the drug packages evaluated are mislabeled. The importance of a capable laboratory staff to support and complement the inspectional staff is apparent from the above data. Three food chemists have received specialized training in pesticide analyses and basic chemical analyses of foods, through a program sponsored and subsidized by the federal Food and Drug Administration.

Laboratories

The division's activities are carried out by the Bureaus of Diagnostic Services, Sanitary Bacteriology, Evaluation, Biologic Products, Virus Diseases and Research, and Toxicology. The results of chemical, bacteriological and radiological examinations provide a continuing evaluation of the sanitary quality and safety of water, milk and other dairy products, and the efficacy of sewage treatment plants.

The division is also responsible for approving local independent laboratories, providing toxicological services to coroners and law enforcement agencies, testing biologic products, and providing specialized reference and consultation services to other laboratories.

Tuberculosis Control

The department maintains a current registry of all reported cases. It has continued efforts to promote hospitalization of all active cases of tuberculosis; to secure the treatment of non-hospitalized cases; to insure the examination of contacts and suspects; to provide for tuberculin testing of school personnel and of school children in grades one, five and nine; to continue documentation and examination of household associates of reactors in grade one and the encouragement of those infected to take chemotherapy in the form of INH for one year.

Milk Control

Safeguarding the health of Illinois milk consumers continues to be a responsibility of the Illinois Department of Public Health. The administration of dairy laws and regulations is gradually being transferred from municipal to state level. The department presently is cooperating with a legislative commission which is conducting a study of laws regulating dairy products. Some legislation is planned to update and repeal outdated statutes.

Franklin D. Yoder, *Director*

ATTEND FORMAL OPENING OF EXHIBITS

Monday, May 18—Mezzanine

11.00 a.m.

Finances & Budgets

SECRETARY-TREASURER

"Progressively" and "vigorously forward" are probably the best words to epitomize and describe the activities of the ISMS for the fiscal year 1969-70. It can safely be said that during this period there have been more important actions and achievements, a wider scope of involvement, more diverse problems related to the interests of the membership (except for the 1965-66 furor concerning Medicare) and a greater unity of coordinated effort by both the membership and the administrative staff than in any other previous year. A perusal of this year's reports of the various councils and committees will verify this statement. Rather than to duplicate the listing of the energetic and successful activities of these groups here, let me say that their efforts were far from shallow in involvement, forceful in intent, unswerving in determination, and in most instances, timely in action "before-the-fact" rather than after.

The most important thing before the medical profession today is quality medical care for the residents of Illinois. Before complete medical care can be provided in all areas of the state, a revision of our present methods of practice and our present curriculum of education may experience many changes.

Comprehensive health planning has become one of the major subjects before the profession today. The most important printed material at the present time is probably the Himler Report. A summary of this important report was sent to county medical society officers and delegates and alternate delegates to ISMS. Before the House meets in May *all county medical societies should express an opinion on the subjects outlined in the summary of the report.* The trustee of your district has a copy of the complete report and should be able to assist you in understanding the many problems in developing an opinion at the "grass roots." Additional copies of the report are available.

All in all, ISMS has had an unusually busy year, not only for its officers and trustees, but also for its councils and their committees. And, as the expansion of involvement has pyramided, the participation of more members has been needed and the response has been gratifying. As I mentioned in my report last year, a quote by Adlai E. Stevenson, Sr., that "We live in a world of change" is probably more true now than before. Judging from the day-to-day additions of new proposals, regulations and changes by the various divisions and segments of governmental agencies, which attempt to modify and regulate

physicians and the delivery of health care in general, the physician of tomorrow will be in greater jeopardy than has any physician at any time under any circumstances of the past. I have only one admonition—if ever there was a need for the ISMS and forty-nine other state medical societies to be concerned, there is a greater need today and in the many tomorrows to develop a unity of action and solidarity of purpose.

House of Delegates

At each annual meeting of the House of Delegates, a complete stenographic record of each session is obtained to insure accuracy in determining the actions and decisions of the House. As Secretary-Treasurer, I have reviewed this transcript to verify its accuracy and completeness. Any Society member who also wishes to review this record is privileged to do so. He need only make his request known to the Secretary-Treasurer or the Executive Administrator. Statistically, the 1969 transcript contains 362 pages, compared with 359 pages in 1968, 450 in 1967, and the 1966 record totaled 439 pages.

So that each delegate could have the actions of the House readily available for his report to his component society, an abstract of the House's major actions was mailed to him within one week after the meeting. In addition, the July, 1969, issue of the *Illinois Medical Journal* contained an official abstract of the transcript for the benefit of each member.

As has been the custom for many years, the abstract form of the 1969 minutes will be presented to the 1970 House of Delegates for approval. In the event of any doubt or questions, reference can always be made to the full transcript for clarification.

An innovation has been made for the members of the House this year. Previous difficulties in managing and handling the multitudinous reports, supplemental reports, resolutions, reference committee reports and other various papers will be simplified by the use of a large, three-ringed, hardback binder which is not only conveniently indexed, but also has a handle on the backbone for carrying and a flap-type extension with a snap on the open end for closure to prevent spillage. Credit for this innovation goes to Mrs. Frances Zimmer.

Membership Record System

In 1967, after several months of preparatory transitional

work, the Society transferred all of its membership and biographic records from IBM punchcards to magnetic tape. In addition to various other benefits and services accruing from this conversion, county societies were offered (without charge) a direct billing service for dues collection. This was available in various degrees, from total billing and collection of dues with lump sum remittance of local dues to the county society, to the providing of dues statements to county societies for their own mailing and collection. Following the first year's "shakedown" operation when the majority of "bugs" and inaccuracies were eliminated from the tape, the system has performed admirably well, saving many counties the time, effort and expense of dues collection. For the 1970 collection, 73 societies were provided this total service and 17 societies were provided the printed forms for their handling. Any society not now taking advantage of this benefit may do so for 1971 by making a request and sending a breakdown of their dues.

The computerization of membership data has generated many additional benefits. As one example, all labels for mailing the *IMJ* and other publications and communications are now prepared by the computer. Multiple sets of address labels are made with one print-out, resulting in a considerable savings with Society costs in this area greatly reduced.

In addition to the labels, rosters of members are prepared periodically in a variety of formats for internal reference, enabling the staff to perform a myriad of assignments not possible prior to the introduction of this system. Two excellent examples of this—and also of the capability and coordination of the staff—were the *IMJ* Socio-Economic Surveys of the membership conducted in 1968 and 1969. The surveys were conceived and designed by the Public Relations Division; approved by the Board of Trustees; programmed by the computer facility; tabulated by the Business Services Division; interpreted by the Public Relations staff; and publicized by the Publications Division. Thus, these unique projects were carried through from start to finish by ISMS, serving as a reminder of the specialized and complete nature of the staff's abilities and the tape's capabilities.

We have added to our computer membership records system, the membership of the ISMS Woman's Auxiliary and the Illinois Medical Assistants Association. We are providing these two organizations with mailing labels and rosters, as they are needed.

We are also providing on a daily basis, the medical education number of our physicians to pharmacies and other institutions to facilitate their filing state and federal forms, such as the IDPA.

While some other state medical societies may have a form of computerization of their activities, or are in the process of developing one, none are as complete or provide the possibility of future expansion, diversification and informational call-back as does the ISMS. I might add that during the past year, with the tape achieving a greater degree of accuracy and fewer changes in it necessary, plus a more selective use of it, marked economies in costs have been possible. To avoid any misunderstanding, let me add that the ISMS *has not* purchased, leased or rented a computer or other processing equipment of any kind. It does have a master tape, which *is* the property of the Society and can be used on any of the latest makes of computers now in general use. As the need arises, computer time is *rented* to accomplish a project.

Communication with Members

One of the most important responsibilities of the Society—or any organization of a similar nature—is the maintenance of adequate and effective communications with

its members. The membership must be kept informed of the Society's activities if its interest is to be maintained and the organization is to serve effectively and fulfill its reason for existence. However, this is only outgoing information; it is not communication. Of equal or possibly of more importance is the return response from the membership to aid and guide those responsible for the actions of the Society. What the membership thinks, needs and wants is vital to successful leadership, especially in times of change and rapid variations in established philosophies, such as now. During the past year—more than ever before—the officers, Board and staff have attempted to reach deep to obtain the opinions, and learn of the problems encountered by the membership. This has been done in a variety of ways—by such projects as the President's Tours, various workshops, individual speakers and the printed word.

The 1969-70 President's Tour lived up to its name more than any previous tour, as the ISMS Auxiliary and Illinois Medical Assistants Association presidents accompanied Dr. Edward Cannady on the state-wide circuit to round out an informative, productive program.

In addition to an evening dinner meeting for physicians and their wives, the President's Tour program featured two afternoon workshops. They were the Workshop on Financial Planning, presented in cooperation with the Society of Professional Business Consultants, and the Workshop on Office Practice, presented in cooperation with the Illinois Clinic Managers Association.

A program on public affairs and legislation rounded out the district-wide meetings, which were held in 10 different towns throughout the state.

In a more personal and individual channel of communication, answers to questions from the membership were instituted in 1968 when a new department, "Membership Forum," was added to each issue of the *IMJ*. Here each member has an opportunity to voice his opinions, pro or con, on any appropriate subject. If a member considers his views important, he certainly should communicate them to the Society's leadership and other members. While all such letters must be signed, the name will be withheld from publication upon request.

The second annual *IMJ* Socio-Economic Survey was conducted last August to learn the membership's views on legislative issues, rising health costs and continuing education. More than 3,500 physicians—or almost 40 percent of the active membership—completed the questionnaire.

Results of the survey were reported and analyzed in the November, December, and January issues of the *IMJ* and have proved extremely valuable in guiding the work of our councils and committees.

To improve communications with future members and to learn how their ideas differ from the general membership, we extended the survey to a cross section of 3,400 medical students, residents and interns.

The results—based on approximately 1,000 responses—proved that there is little if any generation gap between the "Old Guard" and future physicians. In fact, the survey showed that students, residents and interns are in full accord with the general membership on 24 of the 27 issues surveyed, as pointed out in the February issue of *IMJ*.

The *IMJ* and *Pulse* are sent monthly to each ISMS member, the latter financed by a special grant from Hoffmann-La Roche, Inc. From the broad-based *IMJ* to the specific interest *Pulse*, we seek to keep each physician a well-informed and actively-interested member.

One well accepted and informative ISMS communication channel has been temporarily terminated—the monthly calendar of medical events, "*What Goes On.*" The sponsor of this item, Lederle Laboratories, has not been able to

continue to underwrite the cost of its publication. Efforts are continuing to find a sponsor and as soon as one is obtained, publication will commence. Other departments of the Society's communication program will be found in the report of the Publications Committee.

Leadership Conference

A marked change of format featured this year's Leadership Conference held at the Sheraton-Blackstone in Chicago on Sunday, February 8. The Society demonstrated its leadership by presenting a program which was concentrated on two subjects currently in fine focus of importance to each and every member of the Society; Malpractice and Peer Review. A meeting room filled to overflowing with more than 300 physicians, heard vital discussions on each subject and an opportunity for questions and answers made each subject more meaningful.

During the morning session, a Malpractice Seminar discussed all phases of this problem including the national and state situations and what is being done to ease the crisis. Speakers for the malpractice program were George E. Hall, associate to the General Counsel, AMA; Frank M. Pfeifer, ISMS Counsel; Harry Kinser, Illinois Hospital Association Counsel; and attorneys Stephen Milwid and Max Wildman, who discussed lessons to be learned from malpractice cases decided in Illinois.

Dr. Clinton L. Comper, member of the ISMS Medical-Legal Council, spoke on what ISMS is attempting to do about malpractice. He introduced a newly prepared booklet, "The Physician's Liability In Patient Care," that has been sent to all members. Outstanding credit and appreciation must be given to Mr. Frank Pfeifer and Miss Marian Thiele for the development of this booklet especially for this meeting, and to Parker, Aleshire & Co., Skokie, for its publication.

Highlighting the Peer Review program was the unveiling of suggested "guidelines" for establishing peer review at the county level. Guest speakers, who discussed the various aspects of peer review, included Louis A. Orsini, Director, Health Insurance Council; Dr. John C. Troxel, senior vice-president, Medical Department, Blue Shield Plan of Illinois; Dr. Frank J. Jirka, Jr., ISMS Board Chairman; and Dr. Fred Z. White, chairman of the ISMS Council on Economics and Governmental Health Programs. Doctor White presented the "guidelines" and moderated a panel on how to implement them.

A manual on Peer Review, outlining the basic premises of Peer Review for both county and state committees to follow, was prepared by Mr. James Slawny and his PR staff and reproduced in the ISMS office.

At the luncheon, the Conference was addressed by Paul Q. Peterson, M.D., Acting Deputy Surgeon General of the United States Public Health Service, who read a paper on, "Why Governmental Health Programs Need Peer Review," prepared by Jesse L. Steinfeld, M.D., Surgeon General, USPHS, who was unable to be present because of illness.

The audience was very enthusiastic about the subject matter and the method of presentation, and suggested additional meetings of this same format for deeper exploration into both subjects.

Illinois State Fair

For over twenty years, the Society has had a large exhibit annually at the Illinois State Fair in Springfield. This is the one yearly attempt of the ISMS to present itself directly to the general public and thousands pass through or by the exhibit. By means of the distribution of pamphlets of one type or another, depending on the nature of the displays, the public is made aware of at least some activities of the ISMS.

In 1969, changing from the usual format of showing exhibits pertaining to health information and health education, a new method of approach was used—a direct service feature.

In a newly refurbished and attractive area, information was provided to all who had questions concerning health insurance, with emphasis placed on answering questions of those over 65 who did not understand some facets of Medicare. A series of 40 leading questions concerning Medicare-Medicaid prepared by the Public Relations Department were continuously projected on a large screen visible from all directions of approach. This served as a stimulus to many, to come in and obtain answers to questions or misunderstandings.

In addition to the ISMS staff manning the booth, other organizations who participated in the ten-day run by having representatives there and supplying informational literature were Blue Cross-Blue Shield, Continental Casualty Co., Social Security Administration and the Illinois Department of Public Aid. It is quite probable that no other state (or other) medical society has provided a service feature of this nature on so broad a base to so many people as did ISMS this year.

While not as dramatic and eye-catching as some health exhibits of the past have been, the service feature of 1969 can be considered a four-fold benefit for the public, in the obtaining of direct and correct answers to their questions; for the physicians of the state, in that their time in answering questions of this nature was saved and their patients were better informed; for the third parties, by the clearing-up of misunderstandings and eliminating some correspondence; and for the ISMS, since this was emphasized as an ISMS service directly to the public.

Condolence Letters

ISMS has continued sending an individually typed and personally signed letter of condolence, properly worded to fit the occasion, to the families of all deceased members. We have received many gracious and appreciative replies from these expressions of sympathy.

Society's Tax Status

We have requested our auditors Peat, Marwick & Mitchell to conduct a cost accounting survey, so that they can recommend all expenses that may be deductible under our Society's new tax status. It is expected that legally deductible expenses of our publications will equal or slightly exceed advertising and subscription revenues, resulting again in 1969, in no income tax liability.

Membership Statistics

The changes in membership statistics are indicated in the accompanying table.

Increases in the number of society members are subject to the outside influences of the attractiveness of Illinois as an environment for medical practice and the general economic and population growth of the state. Membership has been increasing slightly over the past four or five years, but substantial increase must remain primarily dependent upon these external factors.

Although many medical organizations claim the time and dues of the American physician, only dedicated support from every physician to his local county society, ISMS and the AMA, can avoid the splintering of influence that leads to unsound changes in the role of the physician in society. The state society must be the unified speaking voice of the physician, if a voice is to be heard and recognized.

Membership Statistics

Changes in ISMS membership statistics for the past several years, as recorded in the Society's records, are indicated in the accompanying table.

	1969	1968	1967	1966	1965	1964
Membership as of January 1.....	10,627	10,568	10,607	10,626	10,500	10,145
New Members	370	425	515	517	492	537
Reinstatements	46	40	43	65	43	211
Total added	416	465	558	582	535	748
Dropped during the year:						
Died	190	205	211	191	172	175
Moved from State.....	66	50	151	172	101	47
Resigned	13	6	12	21	28	7
Nonpayment	124	145	223	217	108	164
Total dropped	393	406	597	601	409	393
Membership as of December 31.....	10,650	10,627	10,568	10,607	10,626	10,500
Regular	9,389	9,375	9,335	9,417	9,429	9,412
Residents	223	196	214	250	278	230
Service	101	105	59	51	26	30
Emeritus	472	507	514	484	494	459
Retired	434	403	399	349	334	312
Hardship	31	41	47	52	45	31
Intern				4	20	26
Total	10,650	10,627	10,568	10,607	10,626	10,500

Financial Statement for 1969

A condensed financial statement for 1969 operations is shown here for the benefit of the entire membership. The complete and detailed audited report prepared by Peat, Marwick, Mitchell & Co. for the year ending December 31, 1969, will be distributed to each member of the House of Delegates prior to the meeting and is also available for review at the headquarter's office by any member upon request.

A report containing the 1969 and 1970 budgets, along with the preliminary actual financial statement for 1969 prior to audit was provided by mail to each delegate during February, 1970. This is in keeping with the expressed request of the House that such information be provided no less than 60 days prior to the annual meeting of the

House of Delegates. This enables delegates to review the Society's financial position, cost of projects and operations, and future planning, well before the actual Reference Committee hearings.

In analyzing the Society's income and expenditures, and the evaluation of the 1970 budget, it might be well to briefly review the apportionment of the Society's income.

At the time of the last dues increase, which was effective for 1966 and in accord with a recommendation from the House of Delegates, a five-year plan was set up. Of the \$105.00 annual dues, \$70.00 was to be used for the Operating Fund, \$20.00 allocated for AMA-ERF, \$7.00 added to the Benevolence Fund, and \$8.00 set aside to build-up the Permanent Reserve Fund. At that time, in a wise and far-

Illinois State Medical Society Position Statement—Dec. 31, 1969

ASSETS	Operating Fund	Benevolence Fund	Permanent Reserve Fund	Property Fund	Student Loan Fund	Suppl. Emp. Retirement Fund
Cash	\$298,402	62,568	11,912	11,097	3,325	25,316
Receivables	26,327	203	1,095		6,390	
Investments, at cost		215,554	502,794		42,500	
Student loans					69,083	
Prepayments and advances	9,824					
Office Furniture and Fixtures				91,181		
Interfund Receivables (Payables)	(44,339)	9,271	6,968	(2,028)		
Total Assets	\$290,214	287,596	522,769	100,250	121,298	25,316
LIABILITIES AND FUND BALANCES						
Payables	\$177,527					
Accrued expenses	3,000					
Deferred income	67,053	2,613	6,968			
Fund Balances	42,634	284,983	515,801	100,250	121,298	25,316
Total Liabilities and Fund Balances	\$290,214	287,596	522,769	100,250	121,298	25,316

Income Statement—Operating Fund—Year Ended Dec. 31, 1969

INCOME	
Membership dues—	
Basic Dues—\$105 per member	\$978,238
Plus Allocation from Contingency Reserve	9,313
Total	<u>987,551</u>
Less Allocations	
AMA-ERF—\$20 per member	186,255
HCCI—\$2 per member	18,625
Benevolence Fund—\$5 per member	46,564
Permanent Reserves—\$8 per member	74,502
Subscription to IMJ—\$2.50 per member	23,282
Total Allocations	<u>349,228</u>
Net Membership Dues	638,323
<i>Illinois Medical Journal</i>	139,222
<i>Pulse</i>	28,200
Annual Convention exhibits	14,928
Interest and dividends	33,863
All other	21,219
TOTAL INCOME	<u>\$875,755</u>

EXPENSES	
Board and Officers	\$41,978
ISMS Meetings	31,967
AMA Meetings	26,434
Administration & Business Services	128,696
Management Services—All Divisions	126,080
Public Relations & Economics	96,561
Economics and Insurance	25,034
Legislation & Public Affairs	72,387
Springfield Office	56,316
Educational & Scientific Services	41,827
Publications	21,302
<i>Illinois Medical Journal & Pulse</i>	212,253
TOTAL EXPENSES	<u>880,835</u>
EXCESS OF EXPENSE OVER INCOME	<u>\$ 5,080</u>

sighted move, a Contingency Reserve Fund was established by the Finance Committee and Board, whereby \$2.00 was set aside in 1966, \$1.00 in 1967 and none in 1968. A return to the Operating Fund of \$1.00 in 1969 and \$2.00 in 1970 was planned. This was to be used as a cushion against increased cost of doing business, inflation, etc.

The above basic outline has been followed, except, as approved by the House of Delegates. Two dollars of each full dues paying member's dues was allocated to the Health Careers Council of Illinois from the AMA-ERF fund in 1967, 1968 and 1969. The same amount was given HCCI from the Benevolence Fund. In addition, the 1969 House approved a recommendation to transfer \$10.00 of the \$20.00, 1970 dues allocated AMA-ERF, to the ISMS Educational and Scientific Foundation "to coordinate promotional efforts to end the shortage of physicians and to develop programs to furnish facilities and manpower in 'health deprived' areas."

In balancing the 1970 budget, however, we found that the projected amount of the Contingency Reserve was not quite adequate to meet the cost of inflation, which, according to the BLS index was 6.2%. (The comparable ISMS increase is approximately 5%.) It has therefore been necessary to take an additional \$2.00 from the Benevolence Fund allocation to balance the budget for 1970. This will in no way hamper any effectiveness of the Benevolence Fund or place it in any jeopardy, since its projected reserve goal is nearing attainment.

The \$8.00 allocation to effect a gradual build-up of the Permanent Reserves was made on the advice of the auditors and others experienced in organizational financing; that it should be the policy of an organization such as the ISMS to have a permanent reserve fund equal to one year's annual income, a policy which is approved by the IRS. At the end of 1969, the Permanent Reserves amounted to approximately \$515,700. It had been projected, based on past experience, that the desired Permanent Reserve goal might be achieved by the end of 1973. Whether this can or will be accomplished depends on the decision of using a part of this allocation for the Operating Fund in 1971 and later years to offset the increases due to "cost of living" or "doing business" and inflation in general, thus deferring a dues increase for a few more years. Regardless of the amount allocated annually for the Permanent Reserves, it should be continued regularly until the goal is achieved.

A copy of the projected budget for 1971 will be provided to each member of the House of Delegates in ad-

vance of the 1970 Convention. It should be noted that the budgets developed for 1970 and 1971 are in balance and do not include funds for any new projects. As stated in previous reports, *should the House of Delegates direct any new programs of a major nature, a recommendation as to the method of providing the necessary finances for them should also be provided by the House at the same time.*

Appreciation and Thanks

The officers and trustees of the Society, speaking for themselves and on behalf of the members, fully appreciate the dedicated interest and efforts in the Society's behalf which have been repeatedly demonstrated by the staff and the Executive Administrator, Mr. Roger White. The successful functioning of a state medical society office does not come from the 8-hour-day, 5-day-week pattern common to the usual executive, the factory employee and the vocational craftsman. It is for the added extra hours spent, the suggestions made and improvements effected, the concern resulting in accomplishment, and the capability and willingness to work as a team that we say again this year a sincere "Thank You" with the thought that you, too, are helping us to better serve mankind.

Jacob E. Reisch

Sub-Committee on Medical Benevolence

(Sub-committee of Finance Committee)

During 1969, the Benevolence Committee carried on its list of recipients thirty-two widows and only two physicians. During the year, three of the widows and one of the physicians died; six new recipients were added.

The average total monthly payment to recipients was \$3,850 and the financial audit of the committee and its assets appears with the report of the Treasurer, as prepared by Peat, Marwick and Mitchell, auditors of the various ISMS accounts.

The investments of the committee are made by the Trust Department of the Continental Illinois National Bank & Trust Company and the custodial account charges are paid from the general funds of the Society, since monies paid into the Benevolence Fund cannot be paid to other than a recipient, according to the existing Bylaws under which this committee operates.

When the expenses of this committee are studied by the

reference committee on Finances, Budgets and Publications, the rulings under which the committee functions will be called to its attention.

After a questionnaire was sent to all recipients this year, some eight or nine cases were "pulled" and the committee will be polled to determine whether or not these recipients are getting as much as the committee feels can possibly be paid for her (or his) assistance. Present inflation and the rise in the cost of living has made the members of the committee aware of an inability to provide for these former members or their families as they would

wish to do. A "long look" will be taken in several cases, and changes made if possible.

The Woman's Auxiliary has always been of outstanding assistance to the committee, not only in providing funds, but also in giving personalized assistance to many of these elderly people who not only need money, but also the association with members of the profession and their wives to extend understanding and friendship, as well as material needs.

Keith H. Frankhauser, *Chairman*

Allison L. Burdick,

Leo. P. A. Sweeney

Scientific Program

Highlights . . .

Monday

ILLINOIS SURGICAL SOCIETY—COOK COUNTY HOSPITAL (a.m.)
ILLINOIS OBSTETRICAL & GYNECOLOGICAL SOCIETY—Crystal Room
CRISIS OF THE DYING PATIENT SYMPOSIUM—Old Chicago Room 101
WHAT'S NEW IN AGING SYMPOSIUM—Ruby Room 113
ILLINOIS SURGICAL SOCIETY—Executive Ballroom (p.m.)
MEDICAL EDUCATION & ITS RELATION TO COMMUNITY HEALTH
NEEDS—Louis XVI

Tuesday

SYMPOSIUM ON ALLERGY—Ruby Room 113
DIABETES SYMPOSIUM—House on the Roof
CLINICAL PROBLEMS IN ALLERGY—Ruby Room 113
MEDICAL LIABILITY PROGRAM—Louis XVI
CONTINUING EDUCATION IN PSYCHIATRY FOR PHYSICIANS IN
PRIVATE PRACTICE—French Room 107
PROBLEMS OF DRUG ABUSE—Old Chicago Room 101
RADIOLOGY CONFERENCE—Crystal Room

Wednesday

ACUTE CORONARY CARE SYMPOSIUM—Louis XVI Room
PEDIATRICS CONFERENCE—Crystal Room
DERMATOLOGY CONFERENCE—Gold Room 114
MANAGEMENT OF RESPIRATORY FAILURE—Crystal Room

*This 3-day program is acceptable for 24 elective hours
by the American Academy of General Practice.*

Legislation & Public Affairs

COUNCIL ON LEGISLATION AND PUBLIC AFFAIRS

The Council on Legislation and Public Affairs has met several times since the last meeting of the House of Delegates. Following each meeting the Council has reported in detail to the Board of Trustees and to the membership through the special legislative newsletters, "On the Legislative Scene" and "On The Political Scene."

Federal Legislation

The 91st Congress, which convened in January, is still in session and most likely will be well into the 1970 election year. Bills affecting medicine and health-related fields are large in quantity and varied in quality.

The House Ways and Means Committee, after it completes action on the Administration's welfare reform proposals, will consider amendments to the Medicare and Medicaid programs. The AMA will be among the first witnesses to testify in these closed hearings. Of concern to the Committee will be control of the escalating costs of these Federal medical programs, as well as, at least some consideration of proposals to provide health insurance on a national basis.

The Senate Finance Committee resumed its consideration of Medicare and Medicaid February 24, and 25. The AMA also testified at these hearings. The hearings last year and the staff report earlier this year stressed the abuses of Medicare and Medicaid by physicians and other participants. Better review techniques by carriers and peer review by the medical profession will be pressed as the answer to these abuses.

The AMA and the NMA joined together to denounce Congressional attempts to limit quality medical care programs. Andrew Thomas, M.D., of NMA and Richard Wilbur, M.D., of AMA appeared together and stated that "Congress is going in exactly the wrong direction" on Medicare and Medicaid.

A number of Federal health programs must be extended during the current fiscal year. Those which have passed both Houses and are either through conference or ready for conference include the following: Hill Burton Hospital Construction and Renovation, Community Mental Health Centers, Medical Libraries Assistance, Public Health Schools Assistance, Domestic Migrant Workers Health Services, and Vaccination Assistance Act. Hearings are underway or expected shortly on these programs: Re-

gional Medical Programs (Heart, Cancer and Stroke). Comprehensive Health Planning, Drug Abuse Control Legislation, Mental Retardation Facilities Assistance, Solid Waste Disposal and Clean Air Act.

Amendments have been proposed which would consolidate the Comprehensive Health Planning Program with the Regional Medical Program. Little success in this area is expected at the present time.

In addition to hearings on many of the programs mentioned above, a Senate Anti-Trust Subcommittee was scheduled to begin hearings February 24, on hospital charges and the role of hospital based specialists. The same day a Senate Executive Reorganization Subcommittee was scheduled to begin three days of hearings on legislation to establish a Council of Health Advisors in the White House. A senate Subcommittee on Monopoly (Nelson Subcommittee) was scheduled to resume hearings February 24, on oral contraceptives.

One of the highlights of the 91st Congress has been the continuing battle between Congress and the Administration over the level of appropriations for health and education.

On February 19, the House passed a \$19.4 billion appropriation for the Departments of Labor and HEW. This bill is \$366 million less than the HEW appropriation bill vetoed by the President in January and \$324 million more than the compromise bill President Nixon said he would accept. Top Republican sources indicate that President Nixon will veto the bill in its present form. The HEW appropriations bill goes to the Senate where efforts will be made by the Republicans to reduce it to an amount acceptable by President Nixon.

Many Members of Congress are concerned about the inability of communities in their districts or states to maintain an adequate supply of physicians. The shortage is, of course, especially acute in rural and urban poverty areas. Legislation has been advanced in both Houses of Congress to give Federal assistance to the training of more family physicians. Such legislation has received the support of the AMA. This legislation provides new earmarked financial support for family practice programs including such items as faculty salaries, faculty traineeships, student stipends, support for the development of models of family practice and for remodeling or con-

struction of new facilities essential for family practice programs.

Over eighty bills have been introduced to authorize payment of chiropractic under Part B, Title 18 (Medicare). It is important that Congressmen and Senators realize that this proposal goes against the recommendation of an independent task force appointed by HEW. In addition, the National Council of Senior Citizens, the AMA, the American Public Health Association and the AFL-CIO have all indicated their opposition to the inclusion of chiropractic under Medicare. Late last year an HEW task force on Medicaid recommended that Federal funds not be used to pay chiropractors in the fifteen states which have been paying chiropractors in their Medicaid Program.

In terms of drug abuse legislation now pending in Congress, the AMA has testified on various aspects of all bills. Primarily AMA opposition is to the placing of the administration of such law in the Attorney General's office. Medicine feels such control should be vested in the Department of Health, Education and Welfare.

As the Congress continues its work and the decade of the 70's progresses, no doubt medicine will receive continued abuse from a variety of sources. We must be prepared for both immediate response to false allegations and maintain a controlled reaction to such indictments.

State Legislation

During the 1969 House of Delegates, your Council reported the status or results of proposed legislation affecting medicine, physicians and the health of the citizens of Illinois. The 76th General Assembly met from January 8, 1969 to June 30, 1969, with a short special session last Fall. On April 1, 1970, the Legislature reconvened for the purpose of a fiscal session. All bills considered will deal with either revenue or appropriations.

During the regular session of the 76th General Assembly, 4,199 bills were filed. Of those bills, 2,207 were ultimately passed by both houses. Over 300 of these proposals were considered by the Legislative Council and staff of ISMS and seventy-five were determined to be of primary importance to medicine.

Undoubtedly, the single most significant measure introduced—at ISMS urging—was S.B. 1168. This bill appropriated \$6.1 million to the Chicago Medical School for construction of additional medical teaching facilities. These monies will enable the institution to qualify for an \$8 million Federal grant and build facilities enabling the school to enlarge its first year enrollment from 82 to 160. It should be noted that this appropriation represents the first time in history that public funds were appropriated directly to a private institution. Another bill which the Governor acted on favorably was H.B. 2510 which requires the establishment of a Department of General Practice in the curriculum of each medical school operated by the State.

There were numerous measures enacted in regard to medical treatment for minors. Two of these bills were introduced by former Speaker and present U.S. Senator Ralph Tyler Smith. One of these allows minors, 18 years or older, to give binding, legal consent to medical and surgical procedures; the other makes unnecessary the obtaining of consent by a physician or hospital before rendering emergency treatment to a minor. Another in the "minor" series is a new law allowing minors, 18 years or older, to donate blood without receiving parental consent. Finally, ISMS succeeded in urging the passage of a bill which enables a minor 12 years old or older to

give binding consent to medical treatment for venereal disease. Although the treatment must be reported to the Department of Public Health, the physician may utilize his own discretion in whether or not he notifies the parents.

ISMS successfully urged broadening of the commonly called "Good Samaritan" law to exempt M.D.'s from civil liability as a result of their voluntarily rendering care at the scene of an accident. A total of five bills was introduced, aimed at the liberalization of current abortion statutes—all failed. The subject has been brought up in past sessions and will certainly come up in the future. The plain reality of the situation dictates little chance of such liberalization being successful.

Three bills strongly opposed by ISMS were successfully defeated. The first was an administrative measure to increase your biennial license fee from \$10.00 to \$30.00. With ISMS opposition, the Governor dropped the proposal and later came up with an even greater revenue raising measure—the state income tax. The second would have given licensure status to hearing aid dealers. The third was a measure promulgated by chiropractors, which would have enabled them to give school physicals.

Medicine did well. It was able to do so primarily because of the keen interest some physicians showed on legislative matters. Without the enthusiastic support given by those who called, wrote and wired, their representation in Springfield, the entire program could have been disastrous. The many physicians, who willingly gave their time and made the long trip to Springfield to appear before legislative committees, should be given a special vote of thanks. Finally, the Council extends its most sincere thanks to the fine staff for the many hours of work contributed in our legislative effort.

Coroner Study Committee

A special ISMS ad hoc committee has been appointed to study the Coroner System as it exists in Illinois with a view to making recommendation to Con-Con on alternatives. The Board is on record as favoring removal of the term "coroner" from the constitution. The committee is attempting to coordinate the activities of all groups concerned with this question.

V. P. Siegel, *Chairman*

EYE COMMITTEE

The Eye Health Committee has met with the Illinois State Joint Council of Ophthalmology. During the last meeting three items on the agenda were discussed.

1. The statement of position regarding the role of the ophthalmologist in the diagnosis and management of children referred for dyslexia.
2. A report on a meeting with the Joint Professional Committee of the Illinois Society for the Prevention of Blindness regarding the matter of mandatory office eye examinations.
3. A report on an advisory board to develop eye standards for driver's license regulations to work with the State of Illinois.

Frank J. Kresca, *Chairman*

David L. Brown
Wilbur W. Baumgartner
James R. Fitzgerald
Max Hirschfelder
Edward Kwedar

Lawrence J. Lawson
Charles L. Pannabecker
David Shock
Manuel L. Stillerman
M. Byron Weisbaum

Maurice M. Hoeltgen, *Consultant*

PUBLIC AFFAIRS COMMITTEE

The ISMS Public Affairs Committee has met several times since the 1969 Annual Meeting. To aid the physician and his wife in political education and activity, a comprehensive program was developed and implemented. A brief outline of that program is as follows:

Meetings: Each county medical society was encouraged to sponsor a public affairs program during the year. A list of audio-visual materials and booklets is available for program planning. As part of the 1969 President's Tour, a Public Affairs Workshop was presented to familiarize physicians and their wives with ISMS programs, and to inform them of current political activity such as legislation and Con-Con.

Monthly Newsletters: During 1969, over 2,800 physicians received monthly newsletters on various political topics. "On the Political Scene" brought the physicians "behind the scenes" of current political developments and personalities. During the Illinois legislative session, this newsletter is replaced by "On the Legislative Scene" which reports House and Senate Floor action, committee recommendations and newly introduced bills for consideration, which may affect physicians and the practice of medicine.

Washington Roundup: The Annual Public Affairs Roundup was held February 27-March 1, in Washington D.C., in conjunction with the AMA/AMPAC Workshop. After visiting with their Congressman, participants heard Congressmen Les Arends, Ken Gray and Senator Charles Percy at the luncheon. The afternoon program highlighted an address by Charles Edwards, M.D., Commissioner of the Food and Drug Administration, and a later visit and question-answer session at H.E.W.

Public Affairs Library: The new Public Affairs Library started in December, 1968, was continued during 1969.

Reviews of newly released and recent books appear in the *Illinois Medical Journal* monthly. Subject matter reviewed includes politics, legislation, political parties, voting trends, the Supreme Court, media and government, and para-political topics. Interested physicians can borrow or purchase the books from the ISMS library.

Auxiliary Program: Under the direction of Auxiliary President, Mrs. Sherman Arnold and Legislative Chairman, Mrs. Allen Taylor, the Auxiliary had another active year in Public Affairs activities. An unusually large turn-out of auxiliary members participated in the annual Public Affairs Workshop in Washington D.C. Plans are also underway for an Auxiliary Public Affairs Breakfast in conjunction with the ISMS Annual Meeting. James Sammons, M.D., of Texas, chairman of AMPAC will be the principal speaker.

Annual Public Affairs Dinner: A Public Affairs Dinner is held annually during the ISMS Annual Meeting in May. Last year approximately 300 physicians heard U.S. Senator Robert Packwood speak on national issues. Another nationally known speaker is planned for this year's meeting.

During the AMA Convention in Denver, the ISMS Public Affairs Committee received a special feather in its cap. Alfred Faber, M.D., co-chairman of the Committee, presented a resolution during a Legislative and Public Affairs Council Meeting providing for a central clearing house for all state societies relative to new ideas in the field of legislation and public affairs. The resolution was presented and adopted by the AMA in Denver.

A special thanks is extended by the Public Affairs Committee to the fine staff of the ISMS for the time and effort devoted to the success of our numerous public affairs functions.

Theodore Grevas, M.D., *Chairman*
Alfred Faber, *Co-Chairman*

TASK FORCE ON COMPREHENSIVE HEALTH PLANNING

The Task Force met this year with Frances J. Weber, M.D., Chief of the Division of Health Planning and Resource Development. At this meeting, the State Health Plan for 1970 was explained briefly. Copies of the State Plan will be sent to the members of the Task Force as soon as they are available.

The Task Force will continue to keep up with any changes that may occur in this constantly changing area.

V. P. Siegel, M.D., *Chairman*

Thomas P. deGraffenried

John Howard Kendall

Philip Lynch

E. A. Piszczek

Fred Z. White

Clarke Mangum, *Ex-Officio*

Calls Will Reach You Easily at the '70 Convention

Doctor, please inform your staff that while you are attending the ISMS Convention, you may be reached through the Physician's Message Center from 9:00 a.m. to 5:00 p.m. Monday, Tuesday and Wednesday. Here is the number to remember:

312-372-5386

This is a direct connection which will not go through the hotel switchboard.

Medical / Legal

MEDICAL LEGAL COUNCIL

The Medical Legal Council has met twice during the past year and has reviewed the activities of the Committees on Impartial Medical Testimony, Laboratory Services and Licensure.

During the past eleven years, the Impartial Medical Testimony Program of the ISMS has become firmly established as a viable and effective procedure in the just settlement of personal liability litigation cases. The usual result has been settlement without trial, and only occasionally has an Impartial Medical Testimony examiner been required to testify in Court. Our current panel of examining specialists requires up-dating, for we have lost many colleagues by death and resignation.

The Council, these past two years, has concerned itself primarily with the problem of malpractice claims. In the past year, discussions again had been held jointly with the Chicago and Illinois Bar Associations to consider the possibility of setting up a Malpractice Screening Panel. These two meetings were followed by a general meeting of the Medical-Legal Council. Unfortunately, the Chicago Bar Association's Medical Legal Council notified the ISMS on

February 16, that the Chicago Bar Association had not approved the report of the Medical Legal Council regarding the Malpractice Screening Panel. However, we feel that definite progress has been made and that the screening panel will be set up.

The plan, whatever its final form, is of utmost concern to all physicians. In case of a final rejection of the idea, we suggest that an Impartial Testimony type of panel be set up by the Society, to which lawyers and judges can turn if they wish to have unbiased testimony in particular cases. The present directives of the Supreme Court Justices of the State of Illinois could be implemented in this way.

The Council also participated in the very successful Leadership Conference on February 8th, where an all day conference was held on malpractice and peer review. Doctor Clinton Compere and Frank Pfeifer appeared on the program.

Noel G. Shaw, *Chairman*

George Alvary
William G. McCarthy
Grover L. Seitzinger

Clinton L. Compere
David T. Petty
Andrew John Toman

IMPARTIAL MEDICAL TESTIMONY

Specialists from the Impartial Medical Testimony panel participated in forty-four impartial medical examinations in 1969. Thirty-three of these appointments were for the Illinois Circuit Court, and eleven were for the United States District Court of Northern Illinois.

As in the past, most of the Impartial Medical Testimony orders came from Cook County, and 52% were requests for orthopedic examinations and reports. Only 15% of the IMT orders came from downstate.

The IMT program continues to provide valuable service to the Illinois and U.S. District Courts. Since its original implementation, it has been a vital factor in the resolution of over 270 cases. The program has established itself as a device to be used in relatively important or unusual cases, where there is a wide gap in medical testimony. The importance of the program should not be confused with the volume of its use.

Our current panel of examining specialists requires up-dating, because we have lost many colleagues by death or other attrition. Doctors interested in serving on the panel should contact the Impartial Medical Testimony Committee. The office of the ISMS controls the lists of panelists and supplies the appropriate specialist in rotation. Only occasionally has an examiner been requested to participate more often than once a year.

Those physicians who serve on the panel have earned the thanks and respect of every member of the ISMS.

Clinton L. Compere, *Chairman*

R. Gregory Green
Jerome J. McCullough
Samuel A. Levinson
Vincent C. Sarley

Maurice D. Murfin
Consultants

COMMITTEE ON LABORATORY SERVICES

No Report.

Grover L. Seitzinger, *Chairman*

Ronald Jessen

Peter Soto

John J. Muelle.

Hans Willuhn

Jack Williams

James B. Hartney, *Consultant*

COMMITTEE ON LICENSURE

The chairman attended the American Medical Association Regional Meeting on Quackery. There were no meetings of the sub-committee during the past year.

As chairman of the Committee on Licensure, I heartily support the decision of the board to form a committee to review the Medical Practice Act and, if possible, bring it up to date.

William G. McCarthy, *Chairman*

Ross Hutchison

Raymond B. Murphy

Elliott Parker

Wilson West

ETHICAL RELATIONS COMMITTEE

During the past year no appeals have been filed from the action of county or district ethical relations committees throughout the state. This does not imply that cases have not been tried by the county or district committees, but it does indicate that whatever decisions were reached, proved to be satisfactory to all concerned.

The Ethical Relations Committee of the Board of Trustees does not feel that these circumstances will exist at the close of the next work year of the Society. More opportunities for differences of opinion will arise after the peer review mechanism is established and in operation throughout Illinois.

Since the Peer Review Committee will not have disciplinary powers, all cases involving ethics will be referred to the county or district ethical relations committee for action. If the profession is to perform this important and vital service to the public and to its own membership, no compromise can exist which would jeopardize the integrity and standing of the individual physician and his privilege and duty to practice good medicine.

Willard C. Scrivner, *Chairman*

Fredric D. Lake

William A. McNichols, Jr.

Darrell H. Trumpe

VISIT YOUR EXHIBITS

Sherman House Hotel

Technical Exhibits—

Mezzanine Floor

HOURS

Monday, May 18—
11:00 a.m. to 5:00 p.m.

Tuesday, May 19—
9:00 a.m. to 5 p.m.

Wednesday, May 20—
9:00 a.m. to 5:00 p.m.

Mental Health & Addiction

COUNCIL ON MENTAL HEALTH AND ADDICTION

The Council on Mental Health and Addiction is a new council established since the last annual meeting. It is responsible for the functions of the former Committee on Mental Health and includes among its members the chairmen of the committees on Alcoholism and Narcotics and Hazardous Substances.

The Council is grateful for the assistance given throughout the year by the Illinois Association for Mental Health, the Illinois Psychiatric Society, the Community Action Committee for Mental Health, the AMA Department of Mental Health, the Illinois Department of Mental Health, and the Illinois Mental Health Planning Board, all of which have sent representatives regularly to council meetings. The council attempts to coordinate its activities with many of these groups whenever possible.

During the year the Council considered numerous problems and situations relevant to the practicing physician in the state. There were numerous legislative bills which the Council considered and attempted to influence their legislative outcome and implementation. Among the most important were the legislative actions providing for the transfer of geriatric patients out of state hospitals into nursing homes, which concerned the Council in respect to their implementation. After thorough investigation it was felt that, at least up to the present, the law was being carried out slowly and with deliberation.

The Council expressed its concern over the recently signed law which required separation of adults from patients under age 18 on psychiatric wards in state institutions. The Council felt it was an infringement on the physician's prerogative to make that decision when he felt it would be therapeutically desirable. The Council vigorously opposed the proposed legislation which would make it possible for the Governor to appoint a lay person as Director of Mental Health. The bill, if passed, would have eliminated the requirement for the Director to be a physician. The Council was instrumental in the defeat of the bill and in the recent appointment of a physician to that post.

The Council strongly recommends that all county medical societies become familiar with legislation before the Senate Welfare Committee, which deals with the use of third party carriers to fund medical patients under Public Aid. The Council was concerned over many as-

pects of this complicated bill, but particularly the section which called for psychological counseling but did not specify who would be qualified to give this counseling—a licensed physician or not.

The Council has encouraged the Illinois Psychiatric Society to become more closely involved with the ISMS in the form of shared space and personnel. This is currently being explored with the ISMS Executive Administrator.

In the problems of our state hospitals, the Council has taken the position that it does not believe that the State can preserve the privilege of exempting its own institutions from standards it imposes on private institutions. Efforts should be made toward upgrading the position of state hospitals so that they will comply with state licensing requirements. To explore this possibility which could lead to proposed legislation, the Council has asked the Department of Mental Health to provide the Council with its best information regarding basic requirements which need to be met. It has also requested:

A. The Illinois Psychiatric Society to provide the Council with suggestions as to how social and professional organizations could help the department upgrade state hospitals in order to meet licensing requirements.

B. Voluntary mental health groups, representing consumers, to become involved to the extent possible in non-medical areas.

Future plans include the preparation of a booklet to be sent to each physician outlining, among other things, emergency psychiatric hospitalization procedures and the physician's legal liability in such a procedure.

The Council has met regularly and frequently throughout the year and feels it has accomplished a great deal but at the same time it feels that there are many challenges ahead.

Marshall A. Falk, *Chairman*

Nathaniel S. Apter
Milton C. Bauman
E. Eliot Benezra
Robert S. Daniels
Irving Frank
Abraham Gelperin
Richard J. Graff

Mart Jalakas
John H. McMahan
Walter P. Plassman
B. Harold Shevick
Joseph Skom
Alex Spadoni

Mrs. August Martinucci,
Woman's Auxiliary Representative

COMMITTEE ON ALCOHOLISM

The Alcoholism Committee met regularly with representatives from the Illinois Hospital Association to discuss three major programs.

The first is continuity of professional education, through meetings of county medical societies, having the state medical society accept a resolution that alcoholism is a medical problem, and seminars at annual state society meetings. The sessions at the May 19, 1969, meeting of the medical society and the seminar at the October 24, 1969, meeting of the hospital association conclave were to "standing-room-only" audiences. Subsequent to the latter meeting, the Illinois Hospital Association distributed copies of two publications written by members of our committee to every hospital in Illinois; one each for the administrator, and the president of the attending staff and hospital board of trustees. These were:

1) *The Acute Alcoholic Patient*, an outline of management in the General Hospital. David J. Stinson, M.D.

2) *Management of the Alcoholic in the Emergency Room*. Abraham Gelperin, M.D.

The second program consists of a continuing effort toward public education by all members of the committee through radio sessions, discussions at P.T.A. meetings, consultation to school authorities when possible and participation in multidiscipline seminars. Subjects such as alcoholism and accidents, legislation, control programs in other counties, education of youth, continuity of patient management and extent of services available versus services needed could serve as focal points of public education. There is therefore being developed a proposal for a study in depth of the totality of the problem of alcoholism in representative areas of Illinois. This would include other agencies and groups such as the Department of Public Aid, the State Department of Mental Health, the courts, public safety, the University of Illinois, the Salvation Army, Alcoholics Anonymous, area councils on alcoholism and others as members of an advisory committee. The committee unanimously agreed that any proposed legislation would require thorough research to justify both intent of the law and its applicability.

The third program concerns a review prepared by a group in the law school of Columbia University of a model Alcoholism and Intoxication Treatment Act for the National Institute of Mental Health. This review was thought to be important by the Committee on Alcoholism of the American Medical Association, and it was suggested that the Boards of Trustees of the hospital, medical and bar association of Illinois present it to their memberships for consideration.

Request has been made for allocation of time during the next annual meeting to present a program on alcoholism, its problems and potential solutions.

Abraham Gelperin, *Chairman*

Charles L. Anderson
Richard S. Cook
Mark Larsen

David J. Stinson
John C. Troxel
William H. Wehrmacher

COMMITTEE ON NARCOTICS & HAZARDOUS SUBSTANCES

After laboring diligently for years to alert people to the growing menace of drug abuse, the ISMS Committee on Narcotics now finds itself, individually and collectively, overwhelmed by an aroused public, demanding information through speakers and literature about this

wide-spread, frightening problem. It became apparent early in the year that individual committee members would have to limit speaking engagements to groups of people who would be teaching others, the Committee must seek the cooperation of other agencies concerned with the problem, and also develop some way to catalog the variety of materials now being produced in print and on film by a multitude of organizations from the Kiwanis Club to the National Institute of Mental Health.

Close liaison has been established with the Illinois Narcotics Advisory Council, the Federal Narcotics Bureau, the Chicago Police Department, and the Illinois Drug Abuse Program. Contact has also been made with the Cook County Advisory Council on Drug Education, the Retail Druggists Association and, of course, the American Medical Association's Department of Alcoholism and Drug Addiction. Each meeting of the Committee is attended by representatives of one or more of these cooperating organizations. There is still a pressing need to develop more "experts" on the subject of drug abuse and several avenues have been discussed. One of these possibilities is the establishment of a center having a full-time faculty and library of reference materials, where teachers, physicians and others, could go for training. A more limited approach is through the ISMS Annual Meeting, where the committee will try to teach doctors and paramedical personnel how to teach others in their communities about drug abuse. Ideally, each county should have its own drug abuse resource center.

It is recommended that each county medical society obtain a copy of the *Resource Book for Drug Abuse Education*, published by the National Clearing House for Mental Health Information, Department of Health Education and Welfare, and use this as a guide to building its resource center. Further, it is recommended that each county society review available films on drug abuse and such packaged educational programs as that offered by Lockheed Information Systems of Sunnyvale, Calif., and then decide on a local level what is appropriate for its community. Many films are available to kick-off discussion in a community situation in which a knowledgeable physician is present. There will always be a demand for physicians to speak on drug abuse no matter how qualified others might be on the subject. The committee feels strongly that the profession has an obligation to provide such physician experts in each county.

Early in the year the committee discussed proposals to reduce penalties for first time possession of marijuana. It supported the legislation, subsequently passed, making first time possession a misdemeanor, rather than a felony for these reasons:

1) Penalties for possession of marijuana should not be so severe as those for first time possession of heroin, LSD and other more dangerous drugs.

2) It is not possible to enforce the present law and be able to do a good job of it.

3) By reducing penalties for first offenses in marijuana possession, enforcement agencies can exert more effort toward stopping hard-core drug abuse.

Following the chairman's participation in a television series entitled "Escape to Nowhere," the committee was approached by the National Broadcasting Company seeking cooperation in the production of a group of public service spot announcements. At the same time, representatives of the Illinois Drug Abuse Program informed the committee that it was planning to inaugurate a 24-hour answering service and needed physician volunteers to whom emergencies could be referred. Since this

request could not be filled immediately, television spot announcements cannot include a telephone number where one could turn for help. Instead, there was a suggestion that persons in need of help contact their family doctor, which is another reason that it is imperative that all practicing physicians learn how to treat acute patients and what services are available for follow-up.

Joseph H. Skom, *Chairman*

Richard B. Eisenstein

Kermit T. Mehlinger

H. Frank Holman

David Slight

Jerome H. Jaffee

Robert Strauss

ILLINOIS DEPARTMENT OF MENTAL HEALTH

Mental illness and the symptomatology of mental illness is in actuality a series of illnesses—ranging from specific and traditional psychiatric disorder categories to varying other psycho-social dysfunctions which affect patients and their families.

These are revealed as social incompetence, familial and community disruption, inability to manage financially, etc. Usually these factors cannot be isolated and labeled "psychiatric disorder." Treatment must deal with the total individual and with the social, economic, vocational and educational forces within the community.

The Illinois Department of Mental Health is striving to develop a broadly-based statewide network of comprehensive community mental health services, designed to be readily accessible to the total population. Ultimately, the objective seeks methods for intervening with effective treatment at the onset of disorder, at the time—and in the environment—where the disorder occurs. Treatment is most beneficial when it is developed with as little interruption to the patient's daily routine as is possible.

Community mental health programs are based on (1) successfully dealing with the individual in stress with access to his family and other community resources; (2) maximizing those resources for total intervention; (3) development of linkage with public and private welfare agencies, medical-surgical facilities and vocational agencies; (4) consultation and education so that the community will recognize that a patient can live in their midst without danger to his neighbors, his family or himself.

Prior to 1960, the mental health system as it functioned in Illinois and throughout the country had serious deficiencies. It removed people from their homes and communities and placed them in isolated hospitals for excessive lengths of time. Prolonged hospitalization often is not necessary—even for treating the most acute psychiatric disorders—if rehabilitation services, social work, and other supporting agents are available in the community.

Prolonged hospitalization may damage a person's ability to function as a productive citizen. A person is at the least operative level while he is hospitalized; he often finds refuge in this retreat from reality and becomes dependent upon his hospital environment.

The Department of Mental Health, with limited resources, seeks to provide "back-up" programs for the emerging community services. These include, but are not limited to, inpatient treatment for patients requiring removal from their immediate environment; extensive inpatient care for the small percentage of patients unable to function at any level in the community; intensive outpatient therapy for patients who can function in the community with reinforcement; specialized services for particular problems such as narcotics addiction, alcoholism, mental retardation, multiple-handicapped, etc., and education and consultation for developing an existing community program.

Successful return of patients to productive living is accomplished through a series of steps beginning with a careful and adequate screening of the patient and his problems; as well as an assessment of his resources—his familial and community supports.

Treatment may then take the form of drug therapy, group therapy, day-care, vocational rehabilitation, individual psychotherapy or a combination of these. Family participation and support is especially essential, as is consultation with employers and other care-givers—the schools, nursing homes, physicians, and police.

Such a carefully based community program builds in a highly structured referral system. It also defines the role the various support elements will provide; and it helps stabilize the social setting for patients, potential patients, and "healthy" citizens to live harmoniously. Mental hospitals, zone centers, and the state schools for the mentally retarded then are able to more successfully treat the "high risk" group—those patients at an acute stage of illness where hospitalization is either imminent or mandatory.

For a significant number of these patients, short-term hospitalization with aftercare linked to the community is a most effective way to bring about a return to productivity. In these instances, a brief respite from immediate environmental pressures will assist in helping the patient to reach an ability to respond to treatment.

The Department, operating through contractual agreements with community hospitals can provide payment of hospital costs for medically indigent persons who are mentally ill and in need of immediate diagnostic and short term therapeutic care. Continued care is arranged for appropriate services following the release of such patients. In this way, financial barriers which might preclude the use of local facilities are removed and many mentally ill persons can be treated in their local communities.

A small, but significant, percentage must be considered permanently disabled as far as an ability to contribute economically to society. These are, largely, our elderly—our geriatric patients. Many of these people can live in community settings if they receive support to maximize the potential they retain. This can be accomplished with careful screening to be certain they are able to live in the community harmoniously. Elderly patients, as any other persons, seek to live in as normal a setting as is possible. It is the mark of a mature society to not only provide for the return of totally productive citizens, but to accept and provide for residence of disabled citizens in the community. They, too, can live in dignity and respect and participate in community activities up to their maximal potential.

Legislation approved on Sept. 12, 1969, established machinery whereby all patients in mental hospitals would be examined to determine whether residence in a nursing or sheltered care home might more nearly suit their needs. Provision was made that when any person of advanced years is admitted to a hospital, he shall be given a comprehensive physical and mental examination within seven days, and a study shall be made of his family and community situation to determine whether some program other than hospitalization will meet the needs of such a person, with preference being given to care or treatment in his home community.

Outpatient programs have a specific role in the transition between inpatient care and recovery. Patients may return to the hospital because supporting services in the community either break down or are non-existent. Post-hospitalized people attempting to adjust to community living are not always able to find employment, places to live, manage their own medication, and achieve satisfying social activities. If these supports are not available to them, they frequently withdraw into illness again—their

refuge is the hospital. As this happens, previous success in treating their illness is submerged or minimized.

To effect the necessary network of services requires a careful blending of public and private resources at all levels—local, state and federal. The Department of Mental Health is seeking to expand this network, so that more effective methods for delivering services to people in need may be achieved.

Communities may call upon the state, through the De-

partment, to help them through grants-in aid, consultant contractual agreements, and for assistance in planning.

Department facilities—zone centers, hospitals, and schools—are increasing outpatient services as well as seeking to improve the quality of inpatient care. Outpatient programs measurably assist patients to move from one service to another with less risk of "falling between the cracks." These Department outpatient programs are provided in conjunction with resources of the local community.

John F. Briggs, *Acting Director*

PLAN TO ATTEND THE

Seventh Annual

PUBLIC AFFAIRS DINNER

at the

Illinois State Medical Society

Annual Meeting in May

Monday, May 18

Bal Tabarin

Sherman House

6:00 p.m. Reception

7:00 p.m. Dinner

\$12.50 per person

Public Relations & Membership Services

COUNCIL ON PUBLIC RELATIONS & MEMBERSHIP SERVICES

In view of the mounting criticism directed at physicians for rising health costs, the primary objective of the Council on Public Relations and Membership Services in 1969-70 was:

"To communicate to the public, as effectively as possible, the facts behind doctors' fees and rising health costs."

To accomplish this, the Council implemented a four-part communications program, using ISMS President Dr. Edward W. Cannady as chief spokesman. It included the following projects:

- **Speeches**—Speeches were prepared on the subject and presented to service clubs throughout the state by Dr. Cannady. Following each speech, news releases were distributed to the local media, thus assuring blanket news coverage of the subject.

- **Newspaper Publicity**—A six-part newspaper series on Rising Health Costs was prepared in cooperation with Dr. Cannady and published over his name in seven Downstate dailies including: the *Metro-East-Journal*, *Champaign Courier*, *Decatur Herald*, *Decatur Review*, *Southern Illinoisan*, *Edwardsville Intelligencer* and the *Centralia Sentinel*. The series was well received by both the newspapers and the public.

- **Television**—A 90-minute program was telecast over Station *WHBF-TV* in Rock Island, featuring Dr. Cannady and Walter Livingston of Blue Shield.

- **Envelope Stuffers**—Small, eye-catching pamphlets were printed to tell patients the facts behind physicians' fees. The pamphlets, designed in the shape of a dollar sign, were offered to the membership without cost for inclusion with the physicians' billing or display in his reception room. Some 60,000 pamphlets were requested by almost 300 clinics and solo practitioners.

Medicine Fights Back

Last February, the U.S. Senate Finance Committee staff published a report on the financial problems of Medicare and Medicaid. The report—which stated that 4,300 individual physicians and 900 groups received over \$25,000 from Medicare in 1968—implied that these physicians, along with the entire medical profession, were to blame for the rising health costs and the financial problems of Medicare and Medicaid.

To combat these irresponsible charges, ISMS launched an educational campaign to "set the record straight" re-

garding the committee's charges. The campaign consisted of speeches to service organizations, weekly news releases, publication of a fact sheet for physicians, radio and television interviews and a proposed envelope stuffer.

Since this project was just getting underway when this report was being written, a progress report was not available.

President's Tour

The 1969-70 President's Tour lived up to its name more than any previous tour, as the ISMS Auxiliary and Illinois Medical Assistants Association presidents accompanied Dr. Edward Cannady on the state-wide circuit to round out an informative, productive program.

Purpose of the President's Tour is to tell "Medicine's Story," and Dr. Cannady did just that as he appeared on 13 radio programs, three television stations, and addressed 10 service clubs on such subjects as: rising health costs; the Senate Finance Committee Report on Medicare and Medicaid; the ISMS membership survey; drug abuse; and county health departments.

In addition to an evening dinner meeting for physicians and their wives, the President's Tour program featured afternoon workshops on financial planning and office management.

A program on public affairs and legislation rounded out the district-wide meetings, which were held in 10 different cities throughout the state.

Membership Survey

The Council's communication with the ISMS membership was maintained primarily through the 1969 Survey on Major Issues.

The Council's second annual survey was conducted last August to learn the membership's views on legislative issues, rising health costs and continuing education. More than 3,500 physicians—or almost 40% of the active membership—completed the questionnaire.

Results of the survey were reported and analyzed in the November, December, and January issues of the *Illinois Medical Journal* and have proved extremely valuable in guiding the work of our councils and committees. At least six other state societies have followed ISMS' lead and have announced plans for similar membership surveys.

To improve communications with future members and

to learn how their ideas differ from the general membership, we extended the survey to a cross section of 3,400 medical students, residents and interns.

The results—based on approximately 1,000 responses—proved that there is little if any generation gap between the “Old Guard” and future physicians. In fact, the survey showed that students, residents and interns are in full accord with the general membership on 24 of the 27 issues surveyed, as pointed out in the February issue of *IMJ*.

Medical Journalism Awards

The Medical Journalism Awards program to acknowledge outstanding achievements in medical journalism and stimulate improved radio-TV-newspaper coverage of medical events enjoyed unusual success this past year as over 200 entries were submitted from throughout the state.

Receiving Medical Journalism Awards at the March 7 Awards Dinner were: Radio Stations *WEXI* (Arlington Heights) *WKRS* (Waukegan), and *WGN* (Chicago); Television Stations *WHBF-TV* (Rock Island), *WLS-TV* and *WBBM-TV* (Chicago); Newspapers *Chicago Tribune*, *Chicago Daily News*, *Park Ridge Herald*, *DesPlaines Suburban Times*, *Harvey Tribune*, *Decatur Sunday Herald and Review* and *Illinois State Register*; and free lance writer, Charles Carner.

Honorable Mention citations were presented to: Station *WJOL* (Joliet); *WICS-TV* (Springfield); *Chicago Sun-Times*; *Danville Commercial-News*; *Joliet Herald-News* and *Granite City Press-Record*.

In recognition of their continued excellence in medical reporting over a five-year period, three newsmen were installed in ISMS' Medical Journalism Hall of Fame. The charter members include: Arthur J. Snider, *Chicago Daily News*; Ronald Kotulak, *Chicago Tribune*; and Don Wooten, *WHBF-TV*, (Rock Island).

Journalism Fellowship

Medical Journalism Fellowship recipients for 1969 were reporters Ben Gelman, *Southern Illinoisan* and Reuben Chanco, *Metro East Journal*. The fellowship—established in 1967—encourages reporters from non-metropolitan newspapers to cover medical events and medical society activities.

As recipients, Gelman and Chanco participated in an intensive four-day workshop at the ISMS annual meeting. They were exposed to every phase of convention activity, including reference committee hearings, scientific programs, and the House of Delegates, as well as working in the press room.

Health Education

The Council's health education messages were communicated to the public primarily through newspaper columns and radio interviews and spot announcements. The materials—most of which was edited by Dr. Charles Weigel of our Public Relations Council—included:

- *Dr. SIMS Says*—These short, practical health tips were published in 27 daily and 10 weekly Illinois newspapers throughout the year.

- *Dr. SIMS Talks To Teens*—Supplied to high schools throughout the state in mat and reproduction proof forms, these 300-word health columns were published in approximately 350 school newspapers.

- *Dr. SIMS Health Tips*—These daily, 30-second health messages were aired over 30,000 times by 59 Illinois radio stations.

- *Medical Interview*—This five-minute discussion series was broadcast weekly on 42 radio stations until it was discontinued March 1, 1970.

Fifty Year Club

As in the past, the council will sponsor an annual luncheon for members of the ISMS Fifty Year Club on Tuesday, May 19, 1970, in conjunction with the society's annual meeting. The luncheon will be held in the Louis XVI Room of the Sherman House.

Last year's Fifty Year Club luncheon drew over 150 members and guests, as 50 members of the Chicago Medical Society were installed into the club. The principal speaker was Dr. Walter C. Alvarez, noted lecturer, author and emeritus professor of medicine of the Mayo Graduate School of Medicine.

The Fifty Year Club, organized in 1937, maintains a membership of approximately 500 physicians.

The activities of our Insurance and Medicine-Religion Committees are described in the reports immediately following the Council on Public Relations and Economics.

Matthew B. Eisele, *Chairman*

Lee F. Winkler

Paul A. Van Pernis

Charles S. Vil

Charles J. Weigel

Anna A. Marcus

Henry A. Holle

Consultants

Paul W. Sunderland

Jacob E. Reisch

Mrs. Wilson West, *Auxiliary Representative*

SAMA Representatives

Henry Covelli

Roger W. Rodgers

COMMITTEE ON INSURANCE

During this past year, the Committee on Insurance evaluated proposals for new insurance plans, initiated improvements and promotional mailings on existing programs, and launched an educational campaign on malpractice prevention.

To offset the increasing number of malpractice suits currently being filed against physicians, the committee started an educational program to help Illinois physicians avoid malpractice claims. The first step in this campaign was the publication of a guide entitled, “The Physician's Liability in Patient Care.” Financed by Parker, Aleshire & Co., ISMS-sponsored Malpractice Insurance administrator, the guide includes safeguards physicians can take to forestall court action, how to report a suspected or actual claim to the insurance company and Illinois statutes pertaining to physician liability.

The 36-page booklet was distributed at the February 8 Leadership Conference and mailed to all ISMS members.

Professional Liability Insurance Program

The ISMS-sponsored Professional Liability (Malpractice) Program, approved by the Board of Trustees in January, 1968, has grown considerably since the initial enrollment in June, 1968. The program, underwritten by Employers Group, currently has over 1,100 participants, with only one applicant rejected. A favorable response has resulted from a promotional mailing to all ISMS members.

Major Medical Expense Plan

This plan, underwritten by the Commercial Insurance Company of New Jersey, and approved by the Board in 1965, currently has over 1,600 participants. An optional plan designed specifically to supplement Medicare coverage was added to the Major Medical Program this past year. Medicare Supplement Plan pays a maximum of \$20 per

day for hospital costs with an annual premium of \$78. Promotional literature was mailed to all ISMS members on both the Medicare Supplement and the \$25,000 Super Plan initiated in 1968.

Disability Income Plan

The oldest of the ISMS-sponsored insurance programs, the Group Disability Plan, underwritten by the Commercial Insurance Company of New Jersey, was first offered in 1946 and was formally endorsed by the Board of Trustees in 1963. Enrollment is over 2,100.

Retirement Investment Program

This program, endorsed by the Board of Trustees in 1965, is designed to protect physicians against periods of inflation and recession by investing their contributions in a combination of a Continental Assurance Company Group Annuity and a no-load Stein Roe & Farnham (Mutual) Stock Fund. With this plan, the physician does not have to include his employees, as he must under the Tax Qualified Program.

Total participation in the Retirement Investment Program is currently 174, with \$2 million in investments.

Keogh Program

Current participation in the Tax Qualified (Keogh) Program has increased from 370 at the end of 1968 to 521 at the end of 1969, including 386 for the Stock Fund, with contributions totaling over \$1,520,000.00; and 135 for Annuities, with contributions totaling over \$214,900.00.

Because of the recent trend toward professional corporations, the committee authorized Paul Robinson, administrator of the Keogh and Retirement Plans, to submit to the Internal Revenue Service an extension of the Keogh Plan to include corporations.

The chairman of the Committee on Insurance commends all committee members who have participated with enthusiasm throughout the year.

This report is for information only and requires no action by the reference committee.

Paul A. Van Pernis, *Chairman*

Phillip D. Boren

James B. Flanagan

A. Everett Joslyn, Jr.

Lawrence Knox

COMMITTEE ON MEDICINE AND RELIGION

The Committee on Medicine and Religion is pleased to report on a productive year. Activities focused on prepara-

tions for a half-day program on "Crisis of the Dying Patient" to be presented at the ISMS annual meeting, May 18.

This program's major emphasis will be on the crisis of dying, as it affects the patient, his family, the physician and the clergyman. Objective of the program is to show physicians and clergymen how to deal with their personal reactions to crisis of death, as well as the reactions of patients and family.

Program highlights will include a presentation on "Death and Dying" by Dr. Elizabeth Ross, Chicago psychiatrist, and the Rev. Carl Nighswonger, Chaplain at the University of Chicago Hospitals. The speakers will be introduced by committee chairman, Dr. A. Marcus. Dr. Paul McCleave, chairman of the AMA Medicine & Religion Department, will respond to the principal speakers.

Under the subcommittee chairmanship of Dr. Charles W. Pfister, a medicine and religion exhibit will again appear at the ISMS annual meeting, manned by both physician and clergy members of the committee.

The committee continued to encourage the formation of medicine-religion committees on the county medical society level. It was agreed that many physicians have a desire to set up local committees but need assistance in organizing them. The state committee's role should be to draw interested physicians and clergymen together and provide advice and materials that will facilitate formation of a local committee. Since many doctors may not realize that the committee is available in this capacity, it was agreed that greater efforts should be made to notify doctors of the committee's functions and services. One means of accomplishing this was achieved during the annual President's Tour. ISMS President Edward W. Cannady, M.D. referred physicians expressing interest in establishing local committees to the state committee.

The committee chairman expresses her appreciation to committee members who have made this year's achievements possible.

Anna A. Marcus, *Chairman*

Charles W. Pfister

Robert S. Mendelsohn

Clement P. Cunningham

Very Rev. Msgr. Armand J. Rotondi (M.D.)

Mrs. John W. Koenig, *Auxiliary Representative*

Consultants

Rev. Herman Cook

Rev. John Marren

Nancy Stoit, *SAMA Representative*

Advisors

Mr. Arne Larson, AMA

William B. Rich, M.D.

Physicians' Placement Service

Although the number of placements resulting directly from efforts of the Physicians Placement Service is one less than last year, there is consolation in that we were responsible for more placements in general practice than in recent years. This is somewhat remarkable considering the dwindling number of newly-licensed physicians remaining in general practice.

We claim credit for the following communities having additional general practitioners as a result of our Placement Service: Elizabeth, Hopedale, DuQuoin, Galena, Wauconda, Lemont and Elk Grove Village.

In the specialist area we were responsible for internists' locating in Woodstock, Bloomington and Champaign. An obstetrician located in Macomb through our office and the urgent need for an otolaryngologist in Aurora

was filled. Surgeons were found for Murphysboro and Aurora.

Physicians were found to fill openings at the West Side VA Hospital in Chicago, the Health Service of Western Illinois University in Macomb, and one for a clinic in Maywood. The part time service of a physician was secured for an industrial opening in Chicago.

Listings for many additional physicians were removed during the year. Although we publicized the openings, we are not claiming credit for them being filled as they were filled by physicians not registered. However, in the past we have discovered that the information concerning the openings was given to them by physicians who received it from our office.

Lists of openings for general practitioners have continued to be published in the *Illinois Medical Journal*. Although

most of the physicians receiving the *Journal* are already permanently located, many of them have contacted us to report the openings for additional physicians in their areas. It is one way of keeping the membership informed that we do provide this service.

During the year we made our annual appraisal of openings through the county medical societies. It is interesting to note that almost without exception the secretaries tell us that their membership is most anxious for additional physicians to locate in their areas. This, of course, is in line with a nationwide trend.

It is gratifying for the writer to observe that the profession is now fully aware of the urgent need for physicians, especially in the area of general practice. The correspondence directed to this Division over the last few years has been a constant reminder that it would not be long before the physician-shortage reached the critical stage. It is now an accepted fact by leaders in the Society and others. The writer, who has served as secretary of the Placement Service since its inception after World War II, has been rewarded during the past year to observe the all-out endeavors made by society leaders to see this situation corrected.

During the year we have had 607 physicians on our mailing list, as compared to 606 the previous year. While 366 still receive our notices of openings, 241 have been removed

because they have either found suitable locations elsewhere or have neglected to reply to our followup letters.

A year ago we reported that 1,300 letters had been sent to interns and residents in Illinois hospitals in an effort to have them register with our Placement Service. It is regrettable that less than five percent were sufficiently interested to return the questionnaires sent to them, and up to now there is not a record of even one who has located as a result of this large mailing. This leads to the unfortunate observation that this group is being flooded with material on attractive openings for them. Hopefully some way will be found to see that more physicians receiving their medical training in Illinois will remain here.

Our objectives continue as in the earliest years of the Placement Service: (1) to assist physicians in finding desirable locations in which to establish practice; and (2) to assist communities in finding physicians.

Unfortunately the number of physicians registering—especially in the field of general practice—is not encouraging, while the number of reports of openings for both general practitioners and specialists continues on the increase from one year to the next. During the coming year highest priority will be given to keeping in contact with the general practitioners who register, especially those who have received help from our Student Loan Fund.

TASK FORCE ON PHYSICIAN SHORTAGE and SERVICES TO MEDICALLY DEPRIVED AREAS

The Task Force on Physician Shortage and Services to Medically Deprived Areas was created last summer by the Board of Trustees to initiate programs to alleviate the physician shortage in Illinois, and improve the delivery of health care services in medically deprived areas.

The Task Force believes its primary area of work should be in helping implement the recommendations contained in the Board of Higher Education's Campbell Report. To begin with, the Task Force plans to:

- 1) Encourage the establishment of internship and rotating residency programs in Downstate hospitals.
- 2) Encourage local physicians and community leaders to maintain contact with all local medical students throughout their medical school careers.
- 3) Work with health centers in providing improved health services in urban ghettos.

To alert the public to the seriousness of our physician shortage, the Task Force enlisted the help of Station *WMAQ-TV*, Chicago, in producing a 30-minute television documentary on the subject. The program, called "Crisis of Care," was telecast February 8. The result was gratifying, as viewers from throughout the state wrote to

offer their support and assistance in solving the problem.

Copies of the film have been purchased for service clubs, communities, schools, etc. Efforts will be made to have the program telecast over several Downstate stations this summer to gain as much public support as possible for future legislation, community programs and scholarships if necessary.

We have also been successful in obtaining the help of the Illinois Jaycees, who boast over 13,000 members in 290 chapters throughout the state.

At the time of this writing, the Jaycees have surveyed physician and health care needs of some 35 Illinois communities. As soon as the Task Force has analyzed the survey results, it will initiate a course of action to improve health care delivery throughout the state.

Philip G. Thomsen, *Chairman*

Jack Gibbs

Morgan M. Meyer

Eugene Johnson

Fred A. Tworoger

Alfred J. Faber

Matthew B. Eisele

Ralph Dolkart
Consultants

George Shropshire

Donald Stehr

Social & Medical Services

COUNCIL ON SOCIAL AND MEDICAL SERVICES

During the past year the Council on Social and Medical Services considered several areas of major significance to physicians, including problems in the physical therapy program under Medicare and expedient practices in signing death certificates.

The Council, through its committees, pointed out that some therapists receive too much discretion in ordering and delivering physiotherapy, placing them in the position of practicing medicine. A related problem is therapists who collect usual and customary Medicare fees for unsupervised work performed by aides. The Board of Trustees approved a set of "Guidelines to Physicians When Prescribing Physical Treatment."

Disparity among Illinois physicians in death certification practices was cited. In some cases a death certificate is not signed until after the body has been embalmed. The Board asked the Medical-Legal Council to examine the position of the state society on death certification, clarify legal responsibilities and suggest modifications.

Attention was also focused on improving care for patients in nursing homes. Recommendations for improvements in-

cluded appointment by nursing homes and shelter care facilities of medical directors on a consulting basis, and clarification of nurse-patient-doctor relationships in nursing homes.

The names of four physicians were approved by the Board as nominees to fill a physician vacancy on the Physical Therapy Committee of the Illinois Department of Registration and Education. They are Drs. Arthur A. Rodriguez, Hugh J. McMenamin, Ali Khalili and Albert Siegel.

The Board nominated four physicians for consideration as appointees to the Emergency Medical Services Committee of the Illinois Department of Public Health. They are Drs. Max Klinghoffer, William Hark, Julius Kowalski, and Edwin Lee.

Further details on these and other matters are contained in the committee reports which follow.

Thomas R. Harwood, *Chairman*

Joel Rosen
Henry B. Betts
Max Klinghoffer

W. I. Taylor
Paul G. Theobald
Julian Buser

Thomas T. Tourlentes

COMMITTEE ON AGING

The Committee on Aging considered a number of important issues during the year with professional and community education high priority items. Medicare management problems also figured prominently.

On May 20, at the ISMS Annual Meeting, the committee will present a program entitled "What's New In Old Age," to acquaint physicians with "normal" physical and laboratory changes associated with aging.

The committee is also planning a downstate clinical program on aging to be held in the fall.

Pamphlets describing the pre-retirement film series, "The Time of Your Life" were mailed to progressive industrial and business concerns with known employee relations programs. Six have expressed interest in the series. Efforts also are being made to interest downstate television stations in the series as part of their public service programming efforts.

The Board of Trustees concurred with committee objections to a Medicare policy that (1) physicians certify eligibility of patients requiring extended care and (2) incompetent patients cannot profit from physiotherapy treatment. The committee believes physicians should be responsible only for determining medical need for ex-

tended care. The policy on incompetency would disenfranchise acute stroke patients and patients with mental illness. Position statements were sent to appropriate public and private organizations and received special attention in *PULSE* and the *Illinois Medical Journal*.

The committee also brought two other problems to the attention of the Board. One concerns the reluctance of nurses to start intravenous treatments and collect blood specimens for tests. As a result, a significant number of nursing home patients may not be receiving adequate care.

The other problem involves expedient practices in certifying death. In some instances bodies are being removed to mortuaries without prior examination by a physician. In the judgment of the committee, both problems require prompt and firm action by the Society.

The Committee on Aging wishes to express its appreciation to the trustees and staff for support and help received this past year.

Thomas T. Tourlentes, *Chairman*

Bertram B. Moss
D. M. Roberts

Martin Siefert
Clyde Rulison

Mrs. Maurice Woll, *Woman's Auxiliary Representative*

COMMITTEE ON DISASTER MEDICAL CARE

During the past year, the Committee on Disaster Medical Care continued to emphasize and support activities in the following areas: Packaged Disaster Hospital training programs; ambulance service problems; medical care problems stemming from natural disasters and civil disorders.

Disaster Manual for Hospitals

A revision of the Disaster Manual for Hospitals is in progress and should be completed by mid-1970. Artwork for the covers has already been ordered in preparation for receipt of the revised copy, which will include additional information on emergency communication, Natural Disaster Hospitals, and hospital security during a riot. Partial funding for the proposed 1,000 new manuals is expected to come from the U. S. Public Health Service. The original manual was distributed to more than 2,000 hospitals and disaster planning units throughout the U.S.

Packaged Disaster Hospitals

The committee presided at several PDH training sessions this past year in Elmhurst, Springfield and Chester. The U. S. Public Health Service stated their intention to continue support for all three Illinois PDH training programs.

Medical Self-Help Training

The Medical Self-Help Training Program is funded by the Office of Civil Defense, administered by the U. S. Public Health Service and Mental Health Administration's Division of Emergency Health Services and operated through state and local agencies, professional organizations and volunteer groups. In the seven years since the program's inception, about 10 million Americans have been trained to care for their own or others' medical needs in emergencies. The enrollment in Illinois last year was 212,000, which was second only to California.

A two-day Medical Self-Help Training session for members of the Illinois Medical Assistants Association was held in Dec., 1969. The IMAA participants are planning to hold similar training sessions in their respective communities.

Meetings

In addition, the committee chairman conducted several lectures to nurses and ambulance personnel on disaster plans and acute poisoning; chaired a meeting on Emergency Health Services on Ambulance Care; and lectured to graduates in the School of Public Health at the University of Michigan, Ann Arbor.

The chairman of the Committee on Disaster Medical Care wishes to commend and thank all committee members who have participated with enthusiasm throughout the year.

This report is for information only and requires no action by the reference committee.

Max Klinghoffer, *Chairman*

Harold C. Lueth
William A. Hark
Charles F. Sutton

Melvin Griem
Milton Zemlyn
Jack R. Baldwin

COMMITTEE ON NURSING

The committee directed most of its efforts during the past year toward further development of the ISMS Statement on Acute Cardiac Care. The committee also agreed that each hospital in Illinois should be encouraged to for-

mulate its own statement on the nurse's role in administering experimental drugs, anesthesia in obstetrics and other dependent functions.

At the request of the Illinois Hospital Association, the chairman met with IHA and Illinois Nurses' Association representatives to formulate a statement on acute cardiac care that would be acceptable to all three organizations. The resulting changes were referred to the Illinois Hospital Association executive committee for consideration.

To assure competent medical attention for patients in nursing homes located some distance from private physicians, the committee convinced the Board of Trustees to recommend that the Illinois Department of Public Health strengthen minimum standards for nursing homes and sheltered care facilities by requiring appointment of a medical director on a consulting basis.

The committee also requested the Board to recommend that certification of college-level medical and paramedical educational curricula be transferred from the Illinois Department of Registration and Education to the Illinois Board of Higher Education.

The committee extends its gratitude to the Illinois Nurses' Association and the Illinois Hospital Association for their cooperation over the past year in resolving problems affecting the medical and nursing professions.

W. I. Taylor, *Chairman*

Raymond Firfer

Roger Sondag

H. J. Kolb

Willard C. Scrivner, *Consultant*

Mrs. Thomas Glatter, *Auxiliary Representative*

ADVISORY COMMITTEE TO PARAMEDICAL GROUPS

Activities in the area of paramedical organizations did not warrant a meeting of the Advisory Committee to Paramedical Groups. However, the committee reports continued cooperation with the Illinois Medical Assistants Association.

The committee and staff have provided counsel, professional assistance and part-time secretarial help for the following IMAA activities:

- 1) *President's Tour Workshops*—Workshops on office practice for medical assistants were presented as part of the 1969-70 ISMS President's Tour. Topics covered, included systematizing insurance forms, handling confidential information, and credit and collection. Speakers at the meetings included representatives from the Chicago College of Medical and Dental Assistants and the Illinois Clinic Managers Association. As a result of the recruiting efforts made at these workshops, IMAA membership increased from 485 to 625. Four new county chapters were formed this past year—Macon, Rock Island, LaSalle and Madison.
- 2) *Medical Self-Help Training Course*—A training session to teach emergency medical skills to IMAA members was held December 3-4 at Elmhurst Hospital. The instructor was Dr. Max Klinghoffer, Disaster Medical Care Committee chairman. IMAA participants will conduct similar training sessions for members of their respective communities.
- 3) *"Executive Memo"*—Editing, publishing and distributing the monthly "Executive Memo" with the cooperation of IMAA President, Zelma Bechtol.
- 4) *News Releases*—Preparation of news releases regarding the annual convention, educational symposia and training seminars.
- 5) *Annual Reports*—Printing the officers and committee chairmen annual reports, council meeting minutes and special promotional pieces.

Activities by the Health Careers Council of Illinois have necessitated no actions by this committee.

Although a letter from the committee chairman was mailed to nine Illinois chapters of paramedical groups offering cooperation, none of the groups has requested committee support or counsel on major areas of concern.

This report is for information only, and requires no action by the reference committee.

Paul G. Theobald, *Chairman*

Maynard I. Shapiro

Burton M. Krimmer

Robert E. Lynn

Carl E. Clark, *Consultant*

Edward J. Krol

Daniel Jolivet, *SAMA*

COMMITTEE ON REHABILITATION SERVICES

The Committee on Rehabilitation Services, which met four times during the past year, alerted Illinois physicians to the abuse of physical therapy services under Medicare, and followed this up with a set of guidelines to alleviate the problem.

The committee pointed out that:

- Problems develop because some doctors give physical therapists too much discretion in ordering and delivering services.

- Physicians prescribing physical therapy services for Medicare patients must outline a specific course of treatment, rather than merely directing "physical therapy as needed."

- Many physicians are being taken advantage of because of insufficient information on the various modes of physical therapy.

- All Illinois doctors should be made aware of the problems, potentially damaging to the image of the medical profession. Physical therapy is often given to patients when only maintenance or supportive care is indicated, thereby unjustifiably increasing costs.

To warn physicians of improper prescription of physical

therapy services, the committee published articles in the March issue of *Pulse*, the ISMS newsletter, and in the April issue of the *Illinois Medical Journal*.

The committee has formulated *Guidelines to Physicians When Prescribing Physical Treatment*. Based on federal regulations pertaining to Medicare physical therapy services, the guidelines serve as a valuable tool in advising physicians how to avoid problems. Sub-titles include *Requirements of Physical Therapy Services Reimbursable Under Medicare*, *Distinction Between Physical Therapy Services and Restorative Nursing Care*, and *Recommendations When Prescribing All Physical Treatment Services*.

The committee also cited unnecessary costs in the Medicare program's physical therapy reimbursement plan. Because of a health personnel shortage, some physical therapists are forming corporations and using aides—without supervision—to perform physical therapy treatments. The therapists receive usual and customary fees for work performed by aides, inflating costs. The committee recommended registered therapists, where appropriate, to train staff members of such institutions as nursing homes to perform less critical therapy treatments. The institutions would pay therapists' salaries, reimbursable under Medicare. The end result would be a substantial cost decrease.

The committee began preliminary discussions relative to consideration of revisions to the Physical Therapy Act of 1965. Preliminary discussions were also held on architectural barriers to freedom of movement of the handicapped.

The committee wishes to acknowledge the participation of the committee members and consultants and the guidance and direction of the Board of Trustees.

Henry B. Betts and Joel S. Rosen, *Co-Chairmen*

Bruce C. Ehmke

Joseph L. Koczur

John E. Finch

John G. Meyer

Frank B. Kelly, Jr.

Arthur A. Rodriguez

Frank J. Jirka, Jr., *Consultant*

Scientific Motion Picture Schedule

Scientific Exhibit Hall

Movies will be Shown Daily

From 9:00 a.m. - 4:30 p.m.

The Obsolete Menopause.

The Technique of Intra-articular and Peri-articular Injection.

X-Ray, Ultrasound, and Thermography in Diagnosis.

The Pharmacology of Disordered Sleep: A Laboratory Approach.

The Differential Use of Antibiotic Therapy.

Reasonable Expectations in the Management of Diabetes.

Resolutions

RESOLUTION 70M-1

Introduced by: Rock Island County Medical Society
Subject: PROCESSING OF LICENSURE BY RECIPROCITY IN ILLINOIS

Referred to: Legislation and Public Affairs

WHEREAS, the State of Illinois continues to experience an alarming shortage of qualified physicians, and

WHEREAS, the Board of Medical Examiners at the present time processes applications for medical licensure on the basis of reciprocity or endorsement of the Certificate of the National Board of Medical Examiners only on a quarterly basis, and

WHEREAS, the delay resulting from action on applications when done on only a quarterly basis is a deterrent to qualified physicians seeking licensure by reciprocity or endorsement, therefore be it

RESOLVED, that the Rock Island County Medical Society urges the Illinois State Medical Society to use its resources in seeking to have the Board of Medical Examiners process applications for medical licensure by reciprocity or endorsement on at least a monthly basis when such applications are pending.

RESOLUTION 70M-2

Introduced by: Rock Island County Medical Society
Subject: ELIMINATION OF EXAMINATION FOR LICENSURE BY RECIPROCITY

Referred to: Legislation and Public Affairs

WHEREAS, the State of Illinois continues to experience an alarming shortage of qualified physicians, and

WHEREAS, the Medical Practice Act of the State of Illinois requires an examination for licensure on the basis of reciprocity or endorsement of a National Board of Medical Examiners Certificate obtained prior to 1 January, 1964, except under special circumstances subject to the discretion of the Board of Medical Examiners, and

WHEREAS, qualified physicians have refused to seek licensure in the State of Illinois because of the examination requirement, and consequently have been lost to other states where such a requirement is non-existent, therefore be it

RESOLVED, that the Rock Island County Medical Society urges the Illinois State Medical Society to employ all of its resources in amending the Medical Practice Act to delete the examination requirement for qualified physicians seeking medical licensure by reciprocity or endorsement of a National Board of Medical Examiners certificate.

RESOLUTION 70M-3

Introduced by: DuPage County Medical Society
Subject: THIRD PARTY CARRIERS AND PAYMENT OF FEES
Referred to: Economics and Social Services

WHEREAS, a physician has no contractual agreement with a third-party carrier, and is responsible only to the patient for medical care, with the patient responsible to his physician for payment of fees incurred in receiving medical treatment, and

WHEREAS, modern day medicine is multi-disciplinary in that it frequently demands the services of more than one physician to attend a patient for a given illness, and

WHEREAS, a physician's usual and customary fees, based upon his specialty, experience and geographical area of practice, are not overcharges, therefore be it

RESOLVED, that the following three principles be reaffirmed by the House of Delegates of the Illinois State Medical Society and referred to the proper committees for action:

1) Unless a physician accepts assignment as payment in full, the patient, not the third-party carrier, is responsible for payment of medical fees;

2) A patient should be reimbursed by his insurance carrier for necessary consultation fees; and

3) A physician's fees which are usual and customary in his area should be accepted as such by the carrier, with contractual reimbursement made to the patient, without the carrier implying any "overcharge."

RESOLUTION 70M-4

Introduced by: Madison County Medical Society
Subject: DOCUMENTATION OF THE NEED FOR HEALTH CARE IN ILLINOIS

Referred to: Public Relations and Miscellaneous Business

WHEREAS, it is stated that many people in the State of Illinois are not able to obtain adequate health care, now therefore be it

RESOLVED, that the Illinois State Medical Society document those in Illinois who cannot obtain proper health care, and then propose a solution to the problem.

RESOLUTION 70M-5

Introduced by: Madison County Medical Society
Subject: REORGANIZATION OF THE PUBLIC RELATIONS PROGRAM

Referred to: Public Relations and Miscellaneous Business

WHEREAS, the Public Relations Program of the Illinois State Medical Society has been a relative failure in getting the view point of the private practicing physician before the public, now therefore be it

RESOLVED, that a reorganization of the PR program be carried out within six months after the meeting of the House of Delegates to better utilize the different forms of the news media to get the opinions and knowledge of organized medicine to the public.

RESOLUTION 70M-6

Introduced by: Madison County Medical Society
Subject: REQUEST FOR AN AUDIT OF MEDICARE, MEDICAID PROGRAMS AND IPAC

Referred to: Public Relations and Miscellaneous Business

WHEREAS, a distorted picture is being developed on:

(1) the adequacy of health care in the United States and

(2) the reasons behind the expense and shortcomings of the Medicare/Medicaid programs, and the IDPA, now therefore be it

RESOLVED, that the Illinois State Medical Society conduct an audit for a period of one recent year on the above programs. This audit is to include studies into administrative costs, hospital payments, doctor payments, drug costs, etc., and be it further

RESOLVED, that the findings of the study be taken to the public via all news media, and be it further

RESOLVED, that adequate funds be made available for the above thorough study.

RESOLUTION 70M-7

Introduced by: Madison County Medical Society

Subject: DEVELOPMENT OF A NATIONAL PROGRAM

TO PROMOTE OUR PRESENT MEDICAL CARE SYSTEM

Referred to: Public Relations and Miscellaneous Business

WHEREAS, the American Medical Association is failing to convey the positive reasons for our private system of medical care to the public, and

WHEREAS, the socialist element in this country is now proposing legislation for compulsory national health insurance, and the complete changing of the system of delivery of health care, be it therefore

RESOLVED, that the Illinois State Medical Society, in conjunction with the other state medical societies, urge the American Medical Association to set up a program to utilize all media to promote our present medical care system. This program is to be directed to the public and not the physicians. This program to include a truth squad to shadow HEW and to correct improper and incorrect statements in the news media. This program to be adequately funded by the AMA.

RESOLUTION 70M-8

Introduced by: Madison County Medical Society

Subject: AUDIT OF MEDICARE/MEDICAID TO PROVIDE INFORMATION FOR THE PUBLIC

Referred to: Public Relations and Miscellaneous Business

WHEREAS, the medical profession is being discredited as selfishly enriching itself on governmental health funds out of proportion to services rendered, and

WHEREAS, this distortion depreciates the public image of the medical profession, lessening its ability to make its opinion heard in the formulation of health plans, and

WHEREAS, the medical profession's appraisal of health care plans should be of vital importance to the public which is the voting authority in establishment of such plans, as well as the ultimate supporter of and recipient of services of the health care plans, now therefore be it

RESOLVED, that the Illinois State Medical Society ascertain by audit for a period of one recent year the cost of the Medicare/Medicaid plans, with itemization into administrative cost, physicians' fees, hospital payments, drug costs, etc., and be it further

RESOLVED, that the Illinois State Medical Society bring these figures and their interpretation to the public for its consideration, and be it further

RESOLVED, that the Illinois State Medical Society appropriate adequate funds for the project.

RESOLUTION 70M-9

Introduced by: Madison County Medical Society

Subject: SCHOOL EXAMINATIONS AT KINDERGARTEN, FIFTH AND NINTH GRADE LEVELS

Referred to: Education and Community Health Service

WHEREAS, the load of physical examinations to be done during the summer months and the months immediately preceding the opening of school is excessive, and

WHEREAS, the State laws require complete physicals prior to entry into school in kindergarten, fifth grade and ninth grade, and

WHEREAS, college and athletic physicals are due at the same time, now therefore be it

RESOLVED, that all physicals for entry into kindergarten, fifth, and ninth grades be done within one month of the child's 5th, 10th and 14th birthdays so as to spread out the load of exams in the physician's office, and be it further

RESOLVED, that a copy of this resolution be forwarded to the State Superintendent of Instruction.

RESOLUTION 70M-10

Introduced by: Frank J. Jirka, Jr., Chairman of the Board of Trustees

Subject: DISTRIBUTION OF AMA-ERF UNASSIGNED FUNDS

Referred to: Finances, Budgets and Publications

WHEREAS, an allocation of a portion of each full dues paying member's annual dues is assigned to AMA-ERF, and

WHEREAS, each such physician is privileged to designate the school to which this portion of his dues is to be sent, and

WHEREAS, some fifty percent of our dues paying membership fails to make this assignment and these funds are then divided and distributed among all medical schools in the United States, now therefore be it

RESOLVED, that the House of Delegates authorize the Board of Trustees to request that all such undesigned funds from Illinois State Medical Society dues allocation be divided equally among the Illinois medical schools.

RESOLUTION 70M-11

Introduced by: Fredric Lake, trustee from the Third District

Subject: MEMBERSHIP IN THE HOUSE OF DELEGATES FOR THE ILLINOIS CHAPTER, AMERICAN COLLEGE OF RADIOLOGY

Referred to: Officers and Administration

WHEREAS, The Illinois Chapter of the American College of Radiology embraces virtually all radiologists of the State; and

WHEREAS, its purposes are consonant with those of the Illinois State Medical Society; and

WHEREAS, an affiliation of the Illinois Chapter of the American College of Radiology, with the Illinois State Medical Society would be of mutual benefit,

NOW THEREFORE BE IT RESOLVED that the Illinois State Medical Society grant affiliate status to the Illinois Chapter, and

BE IT FURTHER RESOLVED that such affiliation entitle the Chapter to representation in the House of Delegates.

1970 Annual ISMS Convention

Program Summary by Days

SATURDAY, MAY 16

Noon	Board of Trustees Luncheon	Gold Room 114
2:00 p.m.	Board of Trustees Meeting	Crystal Room
6:00 p.m.	Board of Trustees Dinner	Gold Room 114
6:00 p.m.	Past Presidents Dinner	

SUNDAY, MAY 17

9:00 a.m.	Registration of officers and delegates	Mezzanine
9:00 a.m.	Reference Committee Chairmen	French Room 107
Noon	District Luncheon Meetings	
2:00 p.m.	Credentials Committee	Executive Ballroom Foyer
3:00 p.m.	House of Delegates	Executive Ballroom
5:30 p.m.	Delegates Buffet	Louis XVI Room
7:00 p.m.	Reference Committees	
	Officers and Administration	Holiday Room 105
	Finances, Budgets and Publications	Ruby Room 113
	Constitution and By-laws	French Room 107
	Economics and Insurance	Old Chicago Room 101
	Legislation and Public Affairs	Gold Room 114
	Scientific and Community Health-Education	Crystal Room
	Public Relations and Miscellaneous Business	Time-Life Room 108-110

MONDAY, MAY 18

8:00 a.m.	Registration	Mezzanine
8:00 a.m.	Board of Trustees Breakfast	French Room 107
8:00 a.m.	Illinois Surgical Society	Cook County Hospital
8:30 a.m.	General Session on Obstetrics and Gynecology	Crystal Room
9:00 a.m.	Exhibits open	Mezzanine
9:00 a.m.	Reference Committee on Changes in Bylaws	Louis XVI Room
9:00 a.m.	Medicine and Religion	Old Chicago Room 101
10:00 a.m.	Aging	Ruby Room 113

Noon

	Illinois Obstetrical and Gynecological Society Luncheon	Gold Room 114
1:30 p.m.	General Session on Surgery	Executive Ballroom
1:30 p.m.	Illinois Obstetrical and Gynecological Society	Crystal Room
1:30 p.m.	Medical Education and Its Relation to Community Health Needs	Louis XVI Room
4:00 p.m.	IMPAC Annual Meeting	Gold Room 114
5:00 p.m.	Exhibits close	
6:00 p.m.	Public Affairs Reception and Dinner	Bal Tabarin

TUESDAY, MAY 19

8:00 a.m.	Board of Trustees Breakfast	French Room 107
8:00 a.m.	Registration	Mezzanine
8:30 p.m.	General Session on Allergy	Ruby Room 113
10:30 a.m.	Diabetes Symposium	House on the Roof
Noon	Allergy Foundation Luncheon	Gold Room 114
Noon	USV Pharmaceutical Luncheon	House on the Roof
Noon	50-year Club Luncheon	Louis XVI Room
12:30 p.m.	Preventive Medicine Luncheon	Orchid Room 106
1:30 p.m.	Clinical Problems in Allergy	Ruby Room 113
1:30 p.m.	Continuing Education in Psychiatry for Physicians in Private Practice	French Room 107
1:30 p.m.	General Session on Drug Abuse	Old Chicago Room 101
1:30 p.m.	General Session on Radiology	Crystal Room
1:30 p.m.	Credentials Committee	Executive Ballroom Foyer
2:00 p.m.	House of Delegates	Executive Ballroom
5:00 p.m.	Exhibits Close	
6:00 p.m.	University of Illinois Alumni Reception and Dinner	Crystal Room and Louis XVI Room
6:00 p.m.	President's Reception and Annual Banquet	Grand Ballroom

WEDNESDAY, MAY 20

8:00 a.m.	Board of Trustees Breakfast	French Room 107	Noon	Dermatology Luncheon	Ruby Room 113
8:00 a.m.	Registration	Mezzanine	Noon	Pediatrics Luncheon	French Room 107
9:00 a.m.	Exhibits open		Noon	Chest Physicians Luncheon	Time & Life 108-110
9:00 a.m.	General Session on Acute Coronary Care	Louis XVI Room	12:30 p.m.	IAGP Family Physician Luncheon	Old Chicago Room 101
9:00 a.m.	General Session on Pediatrics	Crystal Room	1:30 p.m.	Workshop on Coronary Care	Louis XVI Room
9:00 a.m.	Chicago Dermatological Society	Gold Room 114	1:30 p.m.	Symposium on Respiratory Failure	Crystal Room
9:30 a.m.	Credentials Committee	Executive Ballroom Foyer	1:30 p.m.	Pathology Slide Seminar	Hektoen Institute
10:00 a.m.	House of Delegates	Executive Ballroom	6:00 p.m.	Board of Trustees Dinner	Randolph Room

HOUSE OF DELEGATES MEETING *Executive Ballroom*

Sunday, May 17	3:00 p.m.
Tuesday, May 19	2:00 p.m.
Wednesday, May 20	10:00 a.m.

REFERENCE COMMITTEE MEETINGS

Sunday, May 17	7:00 p.m.
Officers and Administration	Holiday Room 105
Constitution and By-Laws	French Room 107
Finances, Budgets and Publications	Ruby Room 113
Economics and Social Services	Gold Room 114
Legislation and Public Affairs	Old Chicago Room 101
Public Relations and Miscellaneous Business	Life Room 108
Education & Community Health Services	Crystal Room
Monday, May 18	9:30 a.m.
Changes in Bylaws	Louis XVI Room

BOARD OF TRUSTEES MEETING

Saturday May 16	2:00 p.m.	Crystal Room
Monday, May 18	8:00 a.m.	French Room 107
Tuesday, May 19	8:00 a.m.	French Room 107
Wednesday, May 20	8:00 a.m.	French Room 107
Wednesday, May 20	6:00 p.m.	Randolph Room

Program is acceptable for 24 elective hours by the American Academy of General Practice

Calls Will Reach You Easily at the '70 Convention

Doctor, please inform your staff that while you are attending the ISMS Convention, you may be reached through the Physician's Message Center from 9:00 a.m. to 5:00 p.m., Monday, Tuesday, and Wednesday. Here is the number to remember:

312-372-5386

This is a direct connection which will not go through the hotel switchboard.

Convention Program by Subject

ILLINOIS SURGICAL SOCIETY

George E. Block, President

Frank A. Folk, Secretary

Monday, May 18 **Cook County Hospital**

8:00 a.m. Surgical Clinics, Main Operating Room, 8th floor

Tumor Surgery

SURGEON: Tapas DasGupta, M.D., Associate Professor of Surgery, University of Illinois; Attending Surgeon, Cook County Hospital.

MODERATOR: George Block, M.D., Professor of Surgery, University of Chicago; Orion H. Stuteville, M.D., Professor of Surgery, Northwestern University, Chief, Plastic Surgery, Cook County Hospital; Jack D. Kerth, M.D., Associate Professor of Surgery, Northwestern University, Chief, Otolaryngology Service, Cook County Hospital.

Vascular Surgery

SURGEON: Robert E. Condon, M.D., Professor of Surgery, University of Illinois, Attending Surgeon, Cook County Hospital.

MODERATOR: John J. Bergan, M.D., Associate Professor of Surgery, Northwestern University, Attending Surgeon, Cook County Hospital; Jack L. Gibbs, M.D., Chief of Surgery, Graham Hospital, Canton; Gustav W. Giebelhausen, M.D., Chief of Surgery, Proctor Hospital, Peoria.

Gastrointestinal Carcinoma

SURGEON: Peter Rosi, M.D., Professor of Surgery, Northwestern University, Attending Surgeon, Cook County Hospital.

MODERATOR: Watson Miller, M.D., General Surgeon, Herrin; Herbert B. Greenlee, M.D., Assistant Chief, Department of Surgery, Hines Veterans Administration Hospital; Robert A. DeBord, M.D., St. Francis Hospital, Peoria.

Biliary Surgery

SURGEON: Robert J. Freeark, M.D., Professor of Surgery, Northwestern University, Director, Cook County Hospital.

MODERATOR: Charles B. Puestow, M.D., Clinical Professor of Surgery, University of Illinois; James J. Hines, M.D., Chief, Department of Surgery, Wesley Memorial Hospital, Attending Surgeon, Cook County Hospital; Thomas W. Samuels, M.D., Assistant Professor of Clinical Surgery, Loyola University, Stritch School of Medicine, Decatur and Macon County Hospital.

Resuscitation & Supportive Care

MODERATORS: Frank A. Folk, M.D., Associate Professor of Surgery, Loyola University, Stritch School of Medicine; Director of Surgery, Cook County Hospital; Kenneth H. Schnepf, M.D., Senior Attending Staff (Surgery) at Memorial Hospital and St. John's Hospital, Springfield; Stanley A. Burris, M.D., Attending Staff, Memorial Hospital and St. John's Hospital, Springfield; Robert A. Harp, M.D., Attending Staff, St. John's Hospital and Memorial Hospital, Springfield; David R. Boyd, M.D., Clinical Instructor in Surgery, University of Illinois College of Medicine; Trauma

Service, Cook County Hospital; Robert Brown, M.D., Chief Resident in Surgery, Cook County Hospital.

11:00 a.m. Grand Rounds, Hektoen Institute Auditorium

Chester McVay, M.D., Ph.D., Yankton Clinic, Yankton, South Dakota, Clinical Professor of Surgery, University of South Dakota.

OBSTETRICS & GYNECOLOGY

Monday, May 18

Crystal Room

Presented by

The Illinois Obstetrical & Gynecological Society
Hubert L. Allen, M.D., President

8:30 a.m. Business Meeting

Presiding, Charles F. Kramer, M.D., President-Elect.

8:45 a.m. Case Report

A. "Intrauterine Transfusion"

Merrill Huffman, M.D., Carle Clinic, Urbana.

B. "Non-Genital Pelvic Tumor Hemangio-Pericytoma"

John M. Collins, M.D., Assistant Clinical Professor of Obstetrics and Gynecology, St. Louis University, Belleville.

9:15 a.m. "Genetic Counseling"

James L. Burks, M.D., Department of Obstetrics and Gynecology, University of Chicago, Chicago Lying-In Hospital, Chicago.

9:45 a.m. "Pediatric Illegitimacy"

Robert Kinch, M.B., Chairman, Department of Obstetrics and Gynecology, McGill University, Montreal, Canada.

10:30 a.m. Exhibit Break

10:45 a.m. "Infertile Patient"

Antonio Scommegna, M.D., Department of Obstetrics and Gynecology, Michael Reese Hospital, Chicago.

11:15 a.m. "Induction of Human Ovulation"

Charles Hammond, M.D., Department of Obstetrics and Gynecology, Duke University, Durham, N.C.

12:00 noon Luncheon

Gold Room 114

1:00 p.m. "Cryosurgery"

Thomas L. Ball, M.D., Associate Clinical Professor, Obstetrics and Gynecology, University of California Medical School, Los Angeles, Cal.

1:45 p.m. "Pitfalls In Papanicolaou Smears"

Edward W. Savage, M.D., Department of Obstetrics and Gynecology, University of Illinois Medical Center, Chicago.

2:15 p.m. Installation of New President

Illinois Obstetrical & Gynecological Society

3:00 p.m. "New Concepts in Management of Chorio Carcinoma"

Albert V. Gerbie, M.D., Passavant Memorial Hospital, Chicago.

3:30 p.m. "Labor: Normal vs. Abnormal"

Charles A. Hunter, M.D., Professor and Chairman, Department of Obstetrics and Gynecology, Indiana University Medical Center, Indianapolis, Ind.

MEDICINE & RELIGION

Monday, May 18 **Old Chicago Room 101**
"Crisis of The Dying Patient"

9:00 a.m. Introductions

Anna Marcus, M.D., Chairman

9:05 a.m. "The Dying Patient—His Search For Meaning & Hope"

Elizabeth Kubler Ross, M.D., Assistant Professor of Psychiatry, University of Chicago, and Chief Consultant, Liaison Section, Children and Research, LaRabida Hospital, Chicago.

10:00 a.m. "Crisis of The Dying Patient"

Chaplain Carl Nighswonger, Research Center, Associate, Assistant Professor, University of Chicago Hospital and Medical School, Chicago.

10:30 a.m. Exhibit Break

10:45 a.m. Panel Discussion

Paul McCleave, M.D., Chairman, AMA Medicine & Religion Department, Moderator; Robert Mendelsohn, M.D., Evanston; Patrick Staunton, M.D., Stritch School of Medicine, Loyola University, Hines; Rev. Herman Cook, Chaplain Department, University of Chicago Hospital, Chicago; Randall H. Evans, Divinity School, University of Chicago, Chicago; Robert Desjardins, Stritch School of Medicine, Loyola University, Hines.

AGING

Monday, May 18 **Ruby Room 113**

10:00 a.m. "What's New in Aging?"

Thomas Tourlentes, M.D., Chairman, ISMS Committee on Aging, Assistant Clinical Professor of Psychiatry, University of Illinois.

"A New Dimension in The Chemotherapy of Old Age"

Paul Gordon, Ph.D., Associate Professor, Departments of Pharmacology and Microbiology, Chief of the Geriatric Research Unit, Chicago Medical School.

"The Effects of Aging on Schizophrenic and Mentally Defective Patients: Visual, Auditory and Grip Strength Measurements"

Harold Himwich, M.D., Clinical Professor of Neurology, Stritch School of Medicine, Loyola University, Director of Research, Galesburg State Hospital.

"Normal Abnormalities of Old Age"

Bertram B. Moss, M.D., Clinical Director, Division of Gerontology and Assistant Professor of Medicine, Chicago Medical School.

SURGERY

Monday, May 18 **Executive Ballroom**

Presented by the Illinois Surgical Society
 Charles B. Puestow, M.D., Program Chairman

1:30 p.m. Post Operative Respiratory Care

MODERATOR: James B. Eckenhoff, M.D., Professor and Chief, Department of Anesthesiology, Northwestern University.

PANELISTS: Jack M. Kamen, M.D., Assistant Professor of Anesthesiology, Northwestern University; James R. Webster, M.D., Assistant Professor of Medicine, Northwestern University; Milton Weinberg, M.D., Associate Professor of Surgery, University of Illinois, Attending Surgeon, Cook County Hospital.

2:30 p.m. Surgical Oration: "The Anatomic Basis of Groin Hernia Repair"

Chester McVay, M.D., Clinical Professor of Surgery, University of South Dakota, Yankton, S.D.

3:30 p.m. Esophagitis And Hiatal Hernia

MODERATOR: Lloyd Nyhus, M.D., Professor and Chairman, Department of Surgery, University of Illinois, Attending Surgeon, Cook County Hospital.

PANELISTS: C. Thomas Bombeck, M.D., Instructor in Surgery, University of Illinois; Jack G. Cooley, M.D., Surgeon, Carle Clinic, Champaign; Assistant Professor of Surgery, University of Illinois; John Fennessy, M.D., Associate Professor of Radiology, University of Chicago.

MEDICAL EDUCATION & ITS RELATION TO COMMUNITY HEALTH NEEDS

Monday, May 18 **Louis XVI Room**

Presented by the ISMS Council on
 Education & Manpower
 Jack Gibbs, M.D., Chairman

1:30 p.m. "What Are The Community's Health Needs?"

W. Randolph Tucker, M.D., Health Education Commission

1:50 p.m. "How Relevant Is Present Day Medical Education From the Student's Viewpoint?"

Edward Stulken, University of Illinois Student.

2:10 p.m. "Will The New Medical Schools Be Different?"

Mark H. Lepper, M.D., Rush Medical School; Richard H. Moy, M.D., Southern Illinois University.

2:30 p.m. "Is The State Medical School Responsive To The Need?"

Alexander Schmidt, University of Illinois.

3:00 p.m. Exhibit Break

3:30 p.m. Open Forum

IMPAC ANNUAL MEETING

Monday, May 18 **Gold Room 114**
4:00 p.m.

PUBLIC AFFAIRS DINNER CAMP MEMORIAL LECTURE

Monday, May 18 **Bal Tabarin**

6:00 p.m. Reception & Dinner

8:00 p.m. Address

Speaker to be announced.

ALLERGY

Tuesday, May 19

Ruby Room 113

8:30 a.m. "Physio-pathology and Management of Status Asthmaticus"

Morad Jacobson, M.D., Attending Pediatrician, Michael Reese Hospital, Associate Pediatrician, Lutheran General Hospital, and Assistant Professor of Pediatrics, University of Illinois.

9:00 a.m. "Meteorologic Factors In Distribution of Pollens and Molds—Atomic Fallout"

A motion picture based on previously published papers.

Herman A. Heise, M.D., FACA Emeritus; Eugenia R. Heise, M.T.

9:30 a.m. "The Management of Respiratory Failure In Severe Asthma"

Stanley Deutsch, Ph.D., M.D., Chairman, Department of Anesthesiology, Michael Reese Hospital & Medical Center, Professor of Anesthesiology, Pritzker School of Medicine, University of Chicago.

10:00 a.m. "The Role of Bronchoscopy in the Management of Status Asthmaticus and Its Complications"

Joyce A. Schild, M.D., Associate Attending Bronchologist, The Children's Memorial Hospital, Assistant Attending Otolaryngologist, Presbyterian-St. Luke's Hospital; Clinical Assistant Professor, Department of Otolaryngology, Abraham Lincoln School of Medicine, University of Illinois.

10:30 a.m. Exhibit Break

11:00 a.m. "The Significance of Positive Skin Tests in Allergy"

Richard S. Farr, M.D., Chief, Department of Allergy and Clinical Immunology, National Jewish Hospital and Research Center, Professor of Medicine, University of Colorado Medical Center.

Noon Luncheon

Gold Room 114

12:00

Residents, interns and medical students to be guests of Allergy Foundation of America.

DIABETES SYMPOSIUM

Tuesday, May 19

House on the Roof

10:30 a.m.

ILLINOIS ACADEMY OF PREVENTIVE MEDICINE LUNCHEON

Tuesday, May 19

Orchid Room 106

Noon

FIFTY-YEAR CLUB

Tuesday, May 19

Louis XVI Room

Noon

CLINICAL PROBLEMS IN ALLERGY

Tuesday, May 19

Ruby Room 113

1:30 p.m.

The Chicago Society of Allergy and the Allergy Foun-

dation of America will present ten allergists, each discussing his most difficult case. Attendance by residents, interns and senior medical students especially encouraged.

PARTICIPANTS WILL BE: Robert Becker, M.D., Robert Boxer, M.D., Lawrence Elegant, M.D., Elmer Fisherman, M.D., Donald Frankel, M.D., Martin Kaplan, M.D., Arthur Rosenblum, M.D., Charles Swartz, M.D., Donald Unger, M.D., Leon Unger, M.D.

CONTINUING EDUCATION IN PSYCHIATRY FOR PHYSICIANS IN PRIVATE PRACTICE

Tuesday, May 19

French Room 107

Presented by the Department of Psychiatry and Neurology, Chicago Medical School

1:30 p.m. "Objectives of Continuing Education Program"

H. H. Garner, M.D., Chairman of Department.

1:45 p.m. "Hypochondriasis—Diagnosis and Management"

John Cowen, M.D.

2:15 p.m. Discussion, Illinois Psychiatric Society

PROBLEMS OF DRUG ABUSE

Tuesday, May 19

Old Chicago Room 101

1:30 p.m. "Pharmacologic Review and Treatment of Acute and Chronic Drug State"

Daniel X. Freedman, M.D., Professor and Chairman, Department of Psychiatry, University of Chicago.

2:30 p.m. Discussion

3:00 p.m. Exhibit Break

3:30 p.m. "How to Teach Others In Your Community About Drug Abuse"

Helen Nowlis, Ph.D., University of Rochester.

RADIOLOGY

Tuesday, May 19

Crystal Room

Presented by the American College of Radiology

1:30 p.m. "Manpower Shortage in Radiology: The Training of Paramedical Personnel"

John Campbell, M.D., Professor of Radiology, Indiana University Medical Center, Indianapolis.

2:15 p.m. Exhibit Break

3:00 p.m. "X-Ray Methods and Paramedical Involvement of GI, GU, and Vascular Systems"

Roundtable Discussion: Dr. John Campbell, Chairman, Indiana University School of Medicine, Indianapolis; Dr. Abram Cannon, Associate Professor of Radiology, Northwestern University, Chicago; Dr. George Irwin, Bloomington; Dr. Leon Love, Chairman and Professor of Radiology, Loyola University, Chicago; Dr. George Miller, Radiologist, Champaign-Urbana; Dr. Wylie Mullen, Joliet.

4:00 p.m. Business Meeting

5:00 p.m. Cocktail Party

PRESIDENT'S RECEPTION & ANNUAL BANQUET

Tuesday, May 19 **Grand Ballroom**
6:00 p.m.
 Cocktails, Dinner, Entertainment, Dancing

ACUTE CORONARY CARE

Wednesday, May 20 **Louis XVI Room**

9:00 a.m. "Early Detection of the High Risk Pre-Infarction Patient"

Louis Cohen, M.D., Professor of Medicine, University of Chicago.

9:30 a.m. "Use of Antiarrhythmic Agents in Patients With Acute Myocardial Infarction"

Donald H. Singer, M.D., Director, Reingold E.C.G. Center, Associate Professor of Medicine, Northwestern University School of Medicine.

10:00 a.m. "Heart Block in Patients With Acute Myocardial Infarction"

Kenneth Rosen, M.D., Assistant Professor of Medicine, Director, Department of Adult Cardiology, Cook County Hospital.

10:30 a.m. Exhibit Break

11:00 a.m. "Shock in Myocardial Infarction"

Rolf M. Gunnar, M.D., Professor of Medicine and Director, Section of Cardiology, University of Illinois College of Medicine.

11:30 a.m. Panel

Dr. Cohen, Dr. Singer, Dr. Rosen, Dr. Gunnar.
 MODERATOR: Herbert E. Bessinger, M.D., Clinical Associate Professor of Medicine, University of Illinois College of Medicine; Director of Medical Education; Medical Director, Intensive Cardiac Care Unit, Weiss Memorial Hospital.

2:00 p.m. "The I.C.C.U. Nurse"

Mrs. Catherine Newton, R.N., Supervisor, Intensive Cardiac Care Unit, Weiss Memorial Hospital.

2:30 p.m. Round Tables

"Shock in Myocardial Infarction"

Dr. Gunnar

"Arrhythmias in Myocardial Infarction"

Dr. Singer

"Heart Block in Myocardial Infarction"

Dr. Rosen

"Electrical Hazards on The I.C.C.U."

Jerome Silver, M.D., Clinical Assistant, Professor of Surgery, University of Illinois College of Medicine, Director of Surgical Education and Chairman, I.C.C.U., Weiss Memorial Hospital.

"Administration of the Unit"

Jules Last, M.D., Professor of Medicine, University of Illinois College of Medicine and President, Chicago Heart Association.

"The I.C.C.U. Nurse"

Mrs. Newton

PEDIATRICS

Wednesday, May 20 **Crystal Room**

9:00 a.m. "Management of Hydrocephalus In Children"

Anthony Raimondi, M.D., Professor of Neurosurgery, Northwestern University, Chairman, Division of Neurological Surgery, Children's Memorial Hospital, Chicago.

9:45 a.m. "The Diagnosis of Connective Tissue Disease By Means of Tissue Culture"

Reuben Matalon, M.D., Assistant Professor of Pediatrics, University of Chicago, Chicago.

10:15 a.m. "Psychosexual Differentiation"

John Money, Ph.D., Associate Professor of Medical Psychology and Pediatrics, Johns Hopkins University, Medical Center, Baltimore, Maryland.

11:00 a.m. Exhibit Break

11:15 a.m. "Pulmonary Function Tests in Chronic Lung Diseases in Children"

Patricia Zelkowitz, M.D., Associate in Pediatrics, Northwestern University, Director, Clinical Study Center, Children's Memorial Hospital, Chicago.

DERMATOLOGY

Wednesday, May 20 **Gold Room 114**

9:00 a.m. "Cytosine Arabinoside And Disseminated Herpes"

H. C. Kwaan, M.D., Associate Professor of Medicine, Northwestern University Medical School, and Chief, Hematology Section, Veterans Administration Research Hospital, Chicago.

9:30 a.m. "Cyclophosphamide (Cytoxan) and Pemphigus"

Eugene McKelvy, M.D., Assistant Professor of Medicine, Northwestern University Medical School.

10:00 a.m. "The Background of The Fluorinated Pyrimidines"

Fred Levit, M.D., Assistant Professor of Dermatology, Northwestern University Medical School.

10:30 a.m. Exhibit Break

11:00 a.m. "Use of Methotrexate in Pemphigus"

Walter F. Lever, M.D., Professor of Dermatology and Chairman, Department of Dermatology, Tufts Medical School, Boston, Mass.

11:30 a.m. "Hydroxyurea and Psoriasis"

F. W. Yarbro, M.D., Associate Professor of Medicine and Biochemistry, and Director of Hematology, University of Kentucky Medical Center.

CHEST PHYSICIANS LUNCHEON

Wednesday **Time & Life Rooms 108-110**
Noon

DERMATOLOGY LUNCHEON

Wednesday Ruby Room 113
Noon

IAGP FAMILY PHYSICIANS LUNCHEON

Wednesday Old Chicago Room 107
12:15 p.m.

PEDIATRICS LUNCHEON

Wednesday French Room 107
Noon

MANAGEMENT OF RESPIRATORY FAILURE

Wednesday, May 20 Crystal Room
1:30 p.m. "Controlled Oxygen in Chronic Airway Obstruction" (Acute and Chronic Care)
Thomas L. Petty, M.D., Associate Professor of Medicine, University of Colorado, Denver.

1:50 p.m. "Who and When to Ventilate"
H. Steele Holley, M.D., Associate, Department of Anesthesiology, Northwestern University, Chicago

2:10 p.m. "Mechanical Ventilation and Ventilators"
John T. Sharp, M.D., Professor of Medicine, University of Illinois, College of Medicine, Chief, Cardiopulmonary Laboratory, Veterans Administration Hospital, Hines.

2:30 p.m. Panel for Audience and Participants Questions

3:00 p.m. Exhibit Break

3:30 p.m. "Oxygen Toxicity"
Christen C. Rattenborg, M.D., Professor of Anesthesiology, University of Chicago, Pritzker School of Medicine, Chicago.

3:50 p.m. "Respirator Lung and the Post-Operative Medical Problems"
James R. Webster, Jr., M.D., Assistant Professor of Medicine, Northwestern University, Chicago.

4:10 p.m. "Infections and Respiratory Failure"
Richard H. Parker, M.D., Assistant Professor of Medicine, Northwestern University, Chicago.

4:30 p.m. Panel for Audience and Participants Questions

Scientific Motion Picture Schedule

Scientific Exhibit Hall

Movies will be Shown Daily

From 9:00 a.m. - 4:30 p.m.

The Obsolete Menopause.

The Technique of Intra-articular and Peri-articular Injection.

X-Ray, Ultrasound, and Thermography in Diagnosis.

The Pharmacology of Disordered Sleep: A Laboratory Approach.

The Differential Use of Antibiotic Therapy.

Reasonable Expectations in the Management of Diabetes.

Scientific Exhibits

Title: **Alcoholism: Treacherous but Treatable**
Exhibitors: Vernelle Fox, M.D., L. Guy Chelton, M.D. and Charles Whisnant, M.D.
Institution: Georgia Mental Health Institute, Georgian Clinic Division
Description: The alcoholic has been stigmatized in our culture—even among members of the medical profession. Admittedly, his disease is a complex one to treat. However, the physician's obligation to the alcohol-dependent patient need not be extended to include his being consumed in, nor overwhelmed by the interrelated sociologic and psychologic problems. The exhibit presents an approach to treating the alcohol-dependent patient, with emphasis on: (1) Correct physician attitudes; (2) The medical aspects of patient problems; and (3) Detoxification procedures and referral for correlative rehabilitation programs.

Title: **The Anatomic Basis of Groin Hernia Repair**
Exhibitors: Robert E. Condon, M.D.
Institution: Dept. of Surgery, Univ. of Ill. Coll. of Med.
Description: The exhibit is based upon 160 personal dissections in normal cadavers and on the operative findings in over 350 groin hernia repairs. The anatomic structure of the deep (transversus abdominis) lamina of the abdominal wall is stressed. Three panels serve for identifying data, an introduction and a closing. The laminar organization of the lower abdominal wall is reviewed on one panel, emphasizing the fact that a hernia is a defect in deep musculoaponeurotic layers. Two panels then review dissections of the groin—one from the anterior aspect, the other from the posterior approach. Three panels review the distorted anatomy of each of the three common groin hernias (indirect, direct, femoral) and illustrate the principles of anatomic repair in both the anterior (inguinal canal) and posterior (preperitoneal) methods. The exhibit is accompanied by nine full-scale acrylic resin models of groin dissections which illustrate in three dimensions the points discussed in the accompanying section of the exhibit; these models can be turned and handled by those viewing the exhibit. A brochure will be available for distribution.

Title: **Adequate Medical Care for the Aged**
Exhibitors: F. P. Rhoades, M.D.
Institution: American Geriatrics Society, Inc.
Description: 19 million American aged 65 or over (increasing by 1,000 persons every twenty-four hours). Aging people are afflicted with spe-

cial mental and physical health problems. Insufficient numbers of health professionals trained in geriatrics. Research needed to make increasing life span of man both productive and enjoyable, thereby assuring the right of the aged to live in dignity.

Title: **Craniosynostosis Treated with Zenker's Solution**
Exhibitors: Ronald P. Pawl, M.D. and Oscar Sugar, M.D., Ph.D.
Institution: University of Illinois and Illinois Masonic Medical Center
Description: A review of twenty cases of relatively long followup with crainosynostosis treated with Zenker's solution after craniectomy. The history of treatment with crainectomy alone is reviewed and it is pointed out that foreign bodies are usually interposed, which often extrude later, and that reoperation is often necessary, especially if the coronal suture is involved. The present method was suggested in 1956 and has been in use at the two institutions above since 1958. Because of seizures which were noted after a few of the early cases, three methods of reduction of exposure of the dura to the Zenker's solution were analyzed. Technique and results are discussed and the method is advocated under certain circumstances, which are discussed.

Title: **Subtraction Technique with Color Addition**
Exhibitors: A. K. Bonk, M.D.
Institution: Edgewater Hospital
Description: Subtraction technique with color addition is valuable because it provides: 1) Considerable improvement in quality of the roentgenogram and higher resolution by increased visibility index. 2) By superimposition of films taken at different timing, valuable information can be obtained about dynamics and derangement in blood perfusion. 3) Composite film of arterial and venous circulation gives better definition of anatomical structions. 4) Dramatic illustration of underlying pathology. PROCEDURE: Black and white roentgenograms are printed on color Diazo films; superimposed, producing multi-colored X-rays.

Title: **Total Family Medical Care in Suburbia**
Exhibitors: Edgar G. Wygant, M.D. and J. L. Borde-nave, M.D.
Institution: Individual
Description: This exhibit describes, in part, a specialized approach employed in the practice of medi-

cine in a typical suburban middle-class environment. Because it is well recognized now that the complex interrelationships in the family unit are so important, not only to general mental health but to physical health as well, this medical group's practice takes the whole family into consideration rather than just its individual, separate components.

The sources of stress that are so prevalent today in the middle-class family are presented. They are broken down and illustrated according to the types of demands that are forced upon the individual.

The second stage of the exhibit is structured around the means of medicopsychiatric evaluation and treatment used to handle these family situations, including a discussion of alternate pharmacologic approaches to treatment of patients with emotional disturbances.

Finally, the concept of total-family health is presented with five bonuses of such treatment appropriately illustrated: (1) Continuous or personalized care, (2) more opportunity and time for patient education, (3) Emphasis on prevention and early detection, (4) Early recognition of emotional problems by means of multiple family contacts, and (5) One-stop convenience for patients.

Title: **Unusual Problems in Hair Transplantation.**

Exhibitors: D. Bluford Stough, III, M.D.

Institution: Individual

Description: Through the display of 18-5x8" color transparent photos, this scientific exhibit presents patients with complexities arising during and sometimes after hair transplantation. These problems are displayed with adequate description so as to achieve the most suitable results. Prints of these problems include: a patient with multiple involvements showing extensive scar tissue and resulting infection, graft loss, vascular fistulas and end results after regrowth of hair; also photos of patients who have worn hair pieces causing fracturing of hair and poor hair growth; and "after" photos when patient has undergone epidermal stippling (tattoo) for corrected improvement of poor hair growth (before and after). Foreign body reaction before and after hair growth, and male pattern baldness in the very young adult (18 hrs.) is also shown.

Title: **Selective Bronchial Catheterization and Brushing**

Exhibitors: P. Manalo-Estrella, M.D. and Willard A. Fry, M.D.

Institution: Evanston Hospital & Suburban Cook County T.B. San. Dist.

Description: A new technique for cytologic diagnosis of pulmonary disease.

Title: **Angiography and Radioisotope Scanning in the Diagnosis of Cerebral Pathology**

Exhibitors: John E. D'Abreo, M.D., Joseph J. Drugay, M.D., Ronald P. Pawl, M.D. and William T. Meszaros, M.D.

Institution: Illinois Masonic Medical Center

Description: Angiography and radioisotope scanning are valuable aids in the diagnosis of intracranial disease. These Modalities are complementary, generally reinforcing each other. In some instances, one method is more informative than the other. Representative examples are illustrated.

Title: **Diagnosis of Nonsuppurative Otitis Media, Its Etiology, Complications and Management**

Exhibitors: Wiley H. Harrison, M.D. & Jack D. Clemis, M.D.

Institution: Otologic Professional Associates, s.c. & Northwestern Univ.

Description: This exhibit consists of slide presentations and a continuous movie presentation concerning the diagnosis of nonsuppurative otitis media, its etiology, complications and management. The importance of this frequently overlooked condition which may lead to a child's underachievement in school, speech and language is stressed.

Title: **Plastic Surgical Fees Versus Insurance Company Payments**

Exhibitors: Emanuel M. Herson, M.D.

Institution: Sherman Hospital
Insurance companies discriminate against facial plastic surgical cases. Companies will not pay doctor bills claiming no disease or disability is present. Five plastic surgical procedures in 250 cases prove insurance companies wrong. . . . diseased skin is found microscopically and case studies indicate marked improvement of mental and physical disabilities. Three 4x6" panels illustrated by colored photographs and easily read blocked letters details the above summary.

Title: **Chemotherapy for Recurrent and Invasive Cancer of the Skin**

Exhibitors: Barry A. Goldsmith, M.D.

Institution: Univ. of Ill. and Edgewater and Grant Hospitals.

Description: Carcinoma of the skin is readily apparent, easily accessible and susceptible to treatment. However, two thousand cases per year in the United States die of skin cancer, and many others suffer discomfort, pain and deformity, with worsening, apparently

incurable lesions. The problem is that recurrent cancer of the skin and a few other well-defined categories of skin cancers, are difficult to treat successfully with conventional therapy (i.e. surgery or radiation).

Chemosurgery is a newer form of surgical treatment based on systematic surgical excision of previously chemically-fixed tissue with microscopic control of the entire specimen removed. It has been shown to be highly effective in dealing with these problem cases with conservation of remaining tissue and safety to the patient. The exhibit will describe chemosurgery and explain its indications.

Title: Investigation of a New Mucoadhesive Foam in Proctologic Patient

Exhibitor: Wm. R. Sladek, M.D., F.A.P.S.

Description: The exhibit consists of a short text, tables and illuminated x-rays. It discusses the pathology and complaints usually brought out in histories and examinations of proctologic patients, procedures and therapies. Clinical data are presented on both surgical and non-surgical patients totalling 100 cases treated with the new test drug. Rationale, effectiveness and shortcomings of available methods for the management and treatment of the proctologic patient are discussed.

Title: Visual Screening of Preschool Children

Exhibitor: Eric W. Fantl, M.D.

Institution: Chicago Ophthalmological Society

Description: 1) Reasons for testing visual acuity in preschool children (to detect visual and ocular defects, amblyopia, etc. as early as possible). This is largely in the province of GPs and pediatricians. 2) Demonstration of methods for testing and of the simple tools required. 3) What to do about children with subnormal visual acuity. 4) Possible causes of subnormal vision in preschool children.

Title: Professional Education and Cancer Control

Exhibitor: Steven G. Economou, M.D.

Institution: American Cancer Society, Illinois Division

Description: Table top display of professional 3x5' posters with samples of professional printed material available from the American Cancer Society. A Fairchild projector will show a selection of short films. Order forms available will enable viewers to request additional material.

Title: A Demonstration of Normal Temporal Bone Anatomy and the Histopathology of Common Inner Ear Disorders

Exhibitor: John R. Lindsay, M.D., Horst R. Konrad, M.D.

Institution: Midwestern Temporal Bone Banks Center

Description: The exhibit uses 5x7 ectachrome transparencies of light microscopy material. It is a basic demonstration of normal temporal bone anatomy for orientation and of histopathology of common conditions affecting the sense organ of hearing and equilibrium. Anatomic demonstrations include embryonic, infantile and adult sections. Disorders include those found in early infancy, and in later life.

Title: Health Education for Patients Sitting and Waiting

Exhibitors: Abraham Gelperin, M.D. & Emil Hospoder

Institution: Univ. of Ill.

Description: A free standing booth with compartments for health, education material easily constructed by any hospital maintenance department and supplied by various health agencies with free health information leaflets and booklets eagerly utilized by the sitting and waiting clinic clientele or even your private patients.

Title: Ileostomy Care and Appliances

Exhibitor: Mr. Sheldon Lubin

Institution: Ileoptomists, Inc.

Description: Display case of ileostomy supplies and equipment plus slides shown on a screen depicting ileostomy care and rehabilitation.

Title: Dose Response: Key to Effective Treatment

Exhibitors: Fred J. Phillips, M.D. & C. L. Chai, M.D.

Description: A large segment of patients with arthritis, musculoskeletal and inflammatory problems seen in today's General Practice respond with more predictable results when effective therapy is coupled with a careful dosage program.

A comprehensive management program and the results of our experience with 281 patients over a period of three years employing short as well as long term therapy is presented.

The schedule employed to effect a dose reduction to the smallest maintenance level, thus affording an economic advantage to the patient is outlined.

Technical Exhibits

Booths T-1, 2, 3 DANIELS SURGICAL & MEDICAL SUPPLIES

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NEW-EXCLUSIVE free Hanging MODULAR CABINETRY CONCEPT—Gives you Style, Appearance & Color of Wall Units without actual Wall Attachment—NEW-Disposable SIGMODIDOSCOPE, Disposable VAGINAL SPECULA, LITE; NEW-WALL HANGING VACUUM CAST CUTTER; NEW-SELECTED STORAGE EXAM TABLE & ACCOMPANYING DESK—Choose from TEN STORAGE UNITS to meet your Requirements—Multiple Drawers—Cupboards—Open Storage or No Storage at all. DANCHI Electronic Stethoscope and Portable Mini Tape Recorders, Complete line of SONY Tape Recorders & Colored TV's.

Descriptive Literature is Available on All Displayed Items.

Booth T-4 AUDIO-DIGEST FOUNDATION PACIFIC MEDICAL EQUIPMENT CO.

Audio-Digest Foundation (a non-profit subsidiary of the California Medical Association) gives the busy physician a time-saving tour through the best of some 600 current medical journals, plus the highlights of scores of national meetings. Time-proven, but still unique—these medical tape-recorded services are now offered in reel to reel tape and Phillips type cartridges—General Practice, Surgery, Internal Medicine, Obstetrics & Gynecology, Anesthesiology, Ophthalmology and Pediatrics.

Digest subscribers listen in their car, home or office. Carefully selected tape equipment for playing the Digests is offered at the convention by Pacific Medical Equipment Co.

Booth T-5 BIO-DYNAMICS, INC.

UNITEST SYSTEM—Instrumentation and pre-measured, unitized, disposable chemical reagents for rapid determination of thirteen basic blood tests with laboratory precision. COAGULATION SYSTEM—Advanced digital readout instrumentation and unitized reagents for Prothrombin and partial Thromboplastin determination. MARK X STETHOSCOPE—(Certified) Transmits sounds and murmurs you've never heard before. NEW TEN-LITE STETHOSCOPE—(Certified) A light stethoscope that performs like a heavyweight! FETAL STETHOSCOPE—The new standard in OB auscultation. RADICALLY NEW! UNISCOPE—Low cost, feather weight, disposable/reusable plastic stethoscope.

Booth T-6 CONTINENTAL BIO-CLINICAL LABORATORY

CBC is a pathologist-associated clinical laboratory dedicated to the highest standards of quality testing. This dedication extends to a pricing philosophy through automation and efficiency that allows the prescribing of testing for many more patients than ordinarily possible.

Our staff includes an M.D. Pathologist as director; an M.D. Pathologist as associate director, a Ph.D. in chemistry as well as ASCP, and AMT medical technologists.

CBC specializes in multi-phasic profiles as well as individual tests.

Booth T-7 ILLINOIS MEDICAL ASSISTANTS ASSOCIATION

Booth T-8 MALLINCKRODT PHARMACEUTICALS

Booth T-9 PAUL H. ROBINSON, JR., INC.

Paul H. Robinson, Jr. Incorporated, administers the ISMS Tax-Qualified Retirement Program, and the ISMS Retirement Investment Program.

These are balanced investment programs which offer members advantages they could not otherwise obtain as individuals. The programs include: (1) A mutual fund to provide a vehicle for sound investment in common stock with the possibility of long term capital growth to act as a hedge against periods of inflation; (2) A group annuity to provide a lifetime income as a base income at retirement to act as a hedge against periods of recession.

The ISMS Tax-Qualified Retirement Program meets with the provisions of the Keogh Act and requires the inclusion of full-time employees with three or more years of service.

The ISMS Retirement Investment Program is the Society's basic Retirement Program and does not require the inclusion of full-time employees to participate.

Booth T-10 DYNATECH PRODUCTS CORP.

Booth T-11 BRISTOL LABORATORIES

You are cordially invited to visit our exhibit reflecting Bristol's leadership and enduring commitment to the manufacture of life-saving antibiotics.

For your consideration, the following Bristol antibiotics are featured: POLYCILLIN® (ampicillin trihydrate), KANTREX® (kanamycin sulfate) and PROSTAPHILIN® (sodium oxacillin). Our representatives welcome the opportunity to answer your inquiries.

Booth T-12
MEDICINE AND RELIGION

Booth T-13
GEOTEK RESOURCES FUND, INC.

Geotek Resources Fund offers participation in oil and gas exploration and development, and is mainly a tax sheltered investment.

Booth T-14
NORTH AMERICAN PHARMACAL

North American Pharmacal Company will welcome members of the medical profession at the company's exhibit of leading specialty products. Representatives will be in attendance to answer any questions you may have. North American recently introduced a number of new products which representatives at the exhibit will be pleased to discuss with you. Also available FREE CARICATURE DRAWINGS for physicians. We have a renowned artist at our booth to draw unique caricatures.

Booth T-15
J. B. ROERIG & CO.

Booth T-16
TIME-LIFE, INC.

Booth T-17
CAPITAL CONCEPTS CORP.

Free orange juice is dispensed. Brochures are distributed and registrations are solicited to receive additional or supplemental information dealing with: (1) practice administration; (2) personal budgeting; (3) estate planning; (4) tax sheltered investment programs; (5) professional corporations.

Booth T-21
BIO-MED LABORATORIES, INC.

Bio-Med Laboratories, Inc. is a medically directed clinical laboratory service strategically located in the upper Midwest, thus providing a rapid, reliable service to physicians of this area. The service covers a wide range of procedures, and a very carefully selected group of 17 tests called "Select-A-Panel." This grouping provides the physician with an opportunity at a reasonable cost to construct a test panel offering the most efficient and comprehensive evaluation of his patient.

Booth T-22
UNITED MEDICAL LABORATORIES, INC.

United Medical Laboratories offers the physician low-cost profile studies providing the potential for in-office multiphasic health screening. Profiles can improve patient care by augmenting history and physical exam, detecting pre-symptomatic phases of disease, making or confirming a diagnosis, and establishing patient normal biochemical base lines.

Booth T-23
ASTRA PHARMACEUTICAL PRODUCTS, INC.

Information and descriptive literature pertaining to XY-LOCAINE® (lidocaine) and CITANEST® (prilocaine) local and topical anesthetics, and iron preparations ASTRAFER® (dextriferron) for intravenous use and JECTOFER® (iron sorbitex) for intramuscular administration will be available at the Astra booth.

Booth T-24
PELAM, INC.

Personal Service Laboratories, Regional Automated Laboratory, Contract Laboratory Services, Comprehensive (multiphasic) Health Testing, Medical Systems and Data Processing Services, Medical and Management Consultation, Real Estate Development and Management, Instrument Design and Development. Your inquiry is invited.

Booth T-25
LEDERLE LABORATORIES

Lederle Laboratories is pleased to support the 130th Annual Convention of the Illinois State Medical Society by its presence at this meeting. Our trained representatives will be glad to discuss our well-known brand-name drugs such as DECILOMYCIN®, the world's foremost broad-spectrum antibiotic; ARISTOCORT®, the widely known steroid; the trivalent poliovirus vaccine ORIMUNE®; TUBERCULIN TINE TEST®; and our other products applicable to your practice. Information is also available on our many other services to medicine.

Booth T-26
KEY PHARMACEUTICALS, INC.

Key Pharmaceuticals, Inc., through its own research, developed a new and exclusive method of producing sustained-action tablets. By utilizing the developments of our research, Key has manufactured a number of products which produce sustained-action in treating chronic diseases. We cordially invite you to visit our booth.

Booth T-27
LAKE SIDE LABORATORIES, INC.

Lakeside Laboratories, Inc. exhibit features CANTILS, IMFERON, MERCURYDRIN, METAHYDRIN, METATENSIN and NORPRAMIN.

Booth T-28
FEDERAL BUREAU OF NARCOTICS

Booth T-29
INTERNATIONAL HEALTH SYSTEMS, INC.

Booth T-30
COMPUTA-CHECK LABORATORIES, INC.

Booth T-31
COCA-COLA, USA

Booth T-32
SANDOZ PHARMACEUTICALS

Sandoz Pharmaceuticals cordially invites you to visit our display, where we are featuring MELLARIL, HYDERGINE, SANSERT, CAFERGOT P-B, FIORINAL and BELLERGAL.

Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

Booth T-33
AMERICAN MEDICAL BUILDING GUILD

The booth will include a display case showing 8" x 10" transparencies of building interiors and exteriors, and various descriptive brochures about the company. An American Medical Building Consultant will be at the booth to answer questions.

Booth T-37
INDECON, INC.

Indecon, Inc., Chicago, (branch offices in San Francisco, and Indianapolis) provides a full scope of computer services from programming to facility management. Indecon's Health Services Division is dedicated to serving only the health care field and is demonstrating their computerized Patient Billing System for physicians at Booth No. 37. In addition to automated billing, the System generates all necessary practice management reports and records.

Booth T-39
PHYSICIANS LIABILITY EVALUATING COMMITTEE

Booth T-40
ORTHO COMFORT STORES

Electrically adjustable beds provide proper support while sleeping, watching TV or reading. Medicare and Veterans' pay for them and our Rollassage chairs. Nationwide service at 602-955-7600.

Booth T-41
MERCK SHARP & DOHME

The Merck Sharp & Dohme exhibit has been designed to offer a contribution to your therapeutic armamentarium. Technically trained personnel are available to discuss the scope and variety of services offered to physicians.

Booth T-42
THE UPJOHN CO.

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. They are here to discuss products of Upjohn research designed to assist you in the practice of your profession. They welcome your inquiries and comments.

Booth T-43
MEAD JOHNSON LABORATORIES

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

Booth T-44
PARKER, ALESHIRE & COMPANY

As the administrators of the officially sponsored group insurance programs for members of the ISMS, we invite you to stop at our booth and discuss these fine programs with our representatives.

We have been privileged to administer your group disability plan since 1947, and your group major medical plan since 1958. A malpractice plan was approved in 1968.

The protection available is unexcelled, another benefit of your membership in the ISMS, and deserves your consideration.

Booth T-45
PFIZER LABORATORIES

The Pfizer Laboratories' display has been specifically arranged for your convenience and to give you the maximum in quick service and product information.

To make your visit worthwhile, technically trained Medical Service Representatives will be on hand to discuss with you the latest developments in Pfizer research.

Booth T-46
PM-ILLINOIS, INC.

For over 37 years the PM GROUP has provided a complete business service for the medical profession. The trademark PM is the brand of distinction which identifies Professional Management offices affiliated with Black & Skaggs Associates, Inc., of Battle Creek, Michigan. It assures PM clients that the knowledge, experience and integrity of the oldest and largest such firm in the country are at their command.

You are cordially invited to stop and meet the experienced PM executives there who serve clients here in Illinois.

Booth T-47
SMITH, KLINE & FRENCH LABORATORIES

Representatives will be on hand to answer your specific questions and provide information on their products and services.

Booth T-48
ELI LILLY & CO.

You are cordially invited to visit the Eli Lilly and Company exhibit. Our sales representatives in attendance will welcome your questions about our pharmaceutical products.

Booth T-49
G. D. SEARLE & CO.

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be information on OVULEN-21, OVULEN-28, ENOVID, ALDACTAZIDE, FLAGYL, LOMOTIL, PRO-BANTHINE and other drugs of interest.

Booth T-50
PARKE, DAVIS & CO.

Parke-Davis is proud of more than a century of service to the medical profession. Our representatives consider it a pleasure to contribute to the success of your meeting. They will be present to discuss the quality products from Parke-Davis and welcome your comments or inquiry.

Booth T-51
APACHE CORP.

The function of Apache Corporation, through its subsidiary Apache Oil Programs, Inc., is to organize, offer and manage drilling programs for individuals and corporations whose taxable incomes render attractive and justify the inherent risk of oil participation.

Booth T-52
ABBOTT LABORATORIES

The Abbott exhibit will feature information on a new hematinic IBERET-FOLIC 500™ and a new dosage form of an oral hypnotic and daytime sedative.

Booth T-53
CIBA PHARMACEUTICAL CO.

CIBA Representatives will be on hand to discuss LOCORTEN® (flumethasone pivalate), a new fluorinated corticosteroid specifically designed for the skin.

Booth T-54
ENCYCLOPAEDIA BRITANNICA, INC.

Encyclopaedia Britannica welcomes delegates to the ISMS Convention. As part of EB's 200th Anniversary, we will have on display the great new edition of *BRITANNICA*, *GREAT BOOKS OF THE WESTERN WORLD*, *THE EB REPLICA*, *BRITANNICA JUNIOR*, *ANNALS OF AMERICA*, etc.

Stop and inspect these products in our booth where they are available to the delegates at our convention offer.

Booth T-55
MILLER PHARMACAL CO.

Iron, magnesium, zinc, and calcium in complex forms are designed to support the extra requirements of the body's hundreds of enzyme systems for minerals, vitamins and amino acids during periods of stress and subnormal nutrition. Patients and physicians appreciate these products as an aid in—ALCOHOLISM—ARTHRITIS—DIABETES—HEART DISEASE—OSTEOPOROSIS—PREGNANCY.

Booth T-56
MEDICAL PROTECTIVE CO.

With exceptional proficiency in defense, so essential to the doctor's protection today, the Medical Protective Company offers unexcelled coverage in any claim for damages based upon professional services rendered or which should have been rendered. Its experience from the successful handling of over 98,000 claims during 71 years of Professional Protection Exclusively is unparalleled in the professional liability field.

Booth T-57
BEUTLICH, INC.

Beutlich, Inc. will feature MYKOCERT, the medicated vaginal tampon for the treatment of monilial vaginitis, trichomonas vaginitis, and those infections arising from Gram positive and Gram negative organisms. MANDALAY, the first dual layered methenamine mandelate tablet, and MANDALAY A.P. with phenazopyridine HCL; CEO-TWO the carbon dioxide enema like suppository; PERIDIN-C for the non-hormonal control of the menopausal hot flash will also be shown.

Booth T-58
W. B. SAUNDERS COMPANY

Saunders will have on display a complete line of their medical books, including many new titles and new editions published since last year's meeting. Do stop at our booth.

Booth T-59
DATA SERVICE AGENCY, INC.

Data Service Agency, Inc. serves the medical profession exclusively throughout Illinois and Missouri. They offer the physician, clinic, dentist and pharmacy, a complete accounts receivable service, with built-in sound and proven office management principles. Take your problems to booth no. 59 and plan to leave them there.

Booth T-60
CONTOUR CHAIRS CO.

Booths T-61-62
BLUE SHIELD PLAN
ILLINOIS MEDICAL SERVICE

You are cordially invited to visit the Exhibit Booth of the Blue Shield Plan of Illinois Medical Service. Our Professional Relations representatives will be happy to answer your questions, or to discuss the latest developments in Blue Shield health care protection and Medicare.

Booth T-63
E. R. SQUIBB & SONS, INC.

Members of the medical profession who search for better agents to prevent and treat disease are eager to learn of new products and improvement in products.

Since therapeutic advances are constantly being introduced to the professional market, much valuable product information is available. Your inquiries about the latest results of our research will be welcomed.

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ILLINOIS STATE MEDICAL SOCIETY
MAY 17-20, 1970

ARRIVAL

Day _____ Date _____

Time _____

DEPARTURE

Day _____ Date _____

Rooms held until 6:00 P. M.
 Requests for late arrival held
 until 9:00 P. M.

CHECK OUT TIME 1:00 P. M.

PLEASE CHECK TYPE OF ACCOMMODATION DESIRED

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 WILL BE RESERVED.
 ALL RATES SUBJECT TO ILLINOIS TAX.

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 regarding rates for suites
 upon request.



A Member's Viewpoints

BY MONETTA WAHLBERG/ELGIN

Dear Doctor:

Today, when we were talking about the county medical assistants' meetings, you said, "You've been going to those meetings for a long time—aren't you ever bored with them?" I replied, "No, because I always learn something." After you left, I started thinking about our medical assistants' group and what it has meant to me for the nine years I have been a member. You are usually too busy in the office to talk much about personal items so I am going to write this little memo giving reasons for my continuing interest in our assistants' association.

First, there is seldom a meeting which is not educational and right up-to-date. For instance, last week our speaker was a specialist on the artificial kidney machine; we not only heard how it functioned but had the opportunity to see how it works. Nine years ago, when our group was organized, there wasn't a machine like it in the area so you can see, Doctor, we are keeping up-to-date with our educational programs. In just one year we have covered such important subjects as Malpractice Insurance, Mental Health and Rehabilitation, Social Security Administration, and Profitable Collection Procedures. A new girl in any office could learn much if she attended our meetings.

Another reason for my interest in the group is that there is a continual striving to improve public relations. Not long ago at one of our meetings, an efficient and experienced representative of the telephone company gave a helpful demonstration on the importance of the voice and attitudes

on the telephone. Each member had the opportunity of recording her voice—and that was an "ear-opener" as there was room for improvement in many cases. And along the line of public relations, one of the outstanding speakers recently was a former army chaplain who visits dozens of patients each day in the local hospitals. After hearing him we could not help but be more compassionate and understanding of the patients who come into our office.

And finally, Doctor, because of my membership in the medical assistants' association, I have learned some new and successful office procedures. At one of our meetings a consultant from an auditing service gave us some legal aspects which have been a big help in our collection procedures. Through my friendship and contact with medical assistants in other doctors' offices, it has been possible to secure credit information, names, addresses of relatives, and such seemingly trivial information which can often be of much assistance in keeping good office records.

And now, dear Doctor, aren't you glad both of your medical assistants are members of the county, state, and national medical assistants' association? Why don't you tell your professional friends about our group?

Sincerely,
Your Medical Assistant

For more information, please contact either Mrs. Vivian Johnson, First Vice-President, 9105 S. Albany, Evergreen Park, Illinois 60642 or Mrs. Mary Siers, Second Vice-President, 801 North 84th Street, East St. Louis, Illinois 62203.

when your patients
need continuous
potassium
supplementation...



Black Ink is Vital

BY FRANKLIN D. YODER, M.D.
Director, Illinois Department of Public Health

Accurate record keeping, an integral facet of any organization, is of particular importance in public health since much of the demographic data comes from accurate reporting and recording of health statistics.

It is difficult to imagine a sound program of maternal and child health, or a valid epidemiological study in the absence of vital records and health statistics. Any genetic study of birth defects, for example, which is undertaken without utilizing the State's certified copies of birth, death and fetal death would be much in question. The State Department of Public Health has developed and is in the process of implementing a Total Health Information System (T.H.I.S.) which utilizes vital health statistics as a mechanism to aid in determining health needs and priorities and in planning programs designed to meet the needs.

The initial copies of all vital records should be as sharp and clear as possible. Nearly 90% of the State's local registrars make a photographic reproduction of the certificates which are placed in a permanent file. When the registrar or county clerk receives a request for a certified copy of a certificate, the permanent photocopy is reproduced and a copy is sent to fulfill the request.

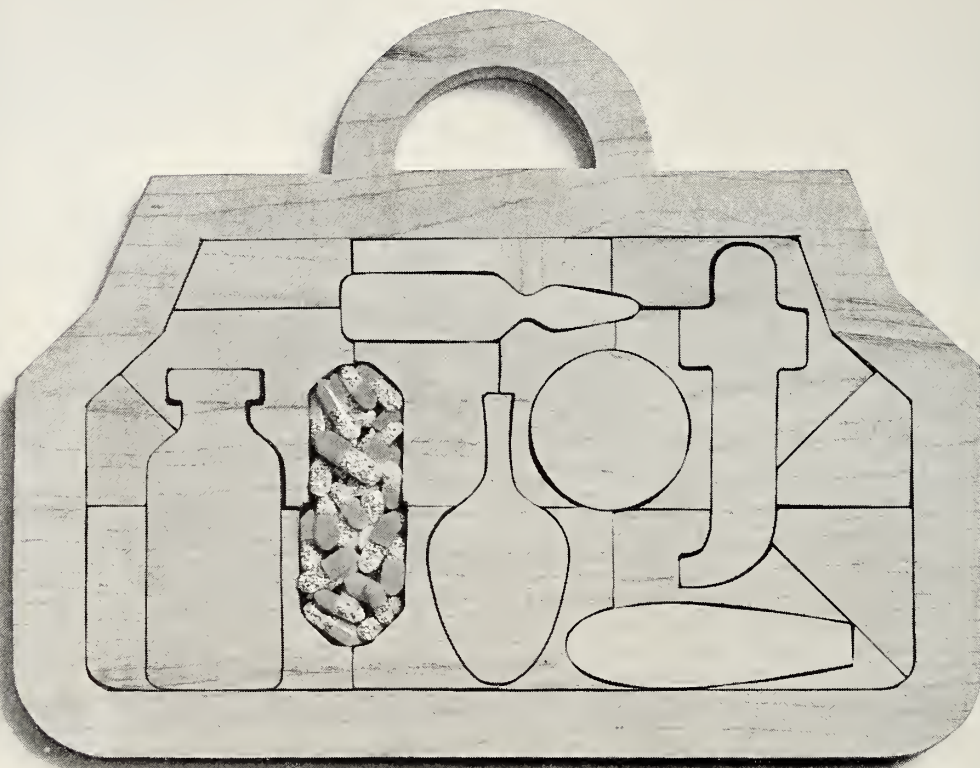
The original birth, death and fetal death certificates are sent to the Department's Bureau of Vital Records where they are microfilmed. One copy of the microfilm is sent to the National Center for Health Statistics where it becomes a part of the permanent national records. Another copy of the microfilm is retained by the State where it is used to fill requests for certified copies of birth, death and fetal death.

In order to insure clear, sharp certified copies from either a photocopy or from microfilm, the original certificate must be prepared either with a clean, black type-writer ribbon or black ink.

As of January 1, 1971, registrars will be required by the Department's Bureau of Vital Records to accept for filing only those certificates which bear the signature and/or entries in black ink. The Department of Public Health urges all physicians, funeral directors, coroners and hospital administrators to begin using black ink immediately, when filling out vital records which will be reproduced. Local registrars and county clerks are being requested to pay particular attention to this standard of acceptability and to bring this request to the attention of any hospital, physician, funeral director or coroner who uses other than black ink.

Cystic Fibrosis

Cystic fibrosis can be a staggering economic drain. Costs of drugs, equipment and other items are large. What cannot be measured are the costs of round-the-clock watchfulness and attention by parents and often siblings, the demanding schedule of visits to doctors, clinics or cystic fibrosis centers, and the strain on family relationships. New problems arise when care of the patient absorbs so much of the parents' time and energy that brothers and sisters feel left out. If there is more than one child with cystic fibrosis in the family, the pressures on overworked, worried mothers and fathers are enormous. It is burdensome just to know that, regardless of the care, cystic fibrosis cannot be outgrown. However, there is some relief in the knowledge that with proper medical and psychological care reasonably average lives can be led by most patients. Small children don't know all the facts of their prospects, but adolescents usually do. (Joseph D. Teicher, "Psychological Aspects of Cystic Fibrosis in Children and Adolescents." *California Medicine*, 110:5 [May] 1969.)



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SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

BY JOSEPH J. LOTHARIUS

"Integrity Program" Launched

Over the objection of the Illinois State Medical Society, the Continental Casualty Company—Medicare (Part B) carrier for most of the state has started a verification of services audit on Medicare claims. This audit, recommended by the Social Security Administration, will be accomplished by taking a random sampling of daily medicare claims and sending letters to either the physician or patient (not to both) involved. The recipient of the letter is asked to verify the services that have been paid for by Medicare. According to Continental, this verification of services audit will be on a continuing basis. No follow-ups of "unreturned" letters is anticipated at this time.

MD's Paid Only 9.9% of IDPA \$'s

Illinois physicians received only 9.9 percent of the total monies paid for federally aided programs in the state from September through November, 1969. According to an IDPA report, \$47,087,479 was paid during this three month period for Medical payments. Of this total, in-patient hospital care accounted for 40.8 percent; nursing home care, 28 percent; drugs, 9.6 percent; and other services, 11.7 percent.

Slight Rise in ISMS Malpractice Rates

A premium increase for the ISMS sponsored Professional Liability Program received Board approval at the March meeting. The increased rates become effective June 1, 1970. According to Parker, Aleshire & Co., the administrator of the plan, the ISMS plan is still too new to develop its own credibility and the carrier was obliged to follow the experience of other insurance companies. The ISMS carrier, Employers Fire Insurance Company, stated that a modest increase at this time may forestall drastic changes in the future. The new increased premium information will be sent to members of the ISMS prior to June 1, 1970.

(Continued on page 463)

The negative power of anxiety...

**This man thinks he may
never work again.**



The patient who has had a myocardial infarction is usually advised by his physician to avoid emotional excitement. All too often his family, acutely concerned, transmits its anxiety to him, urging him to "rest, rest."

How anxiety may interfere

In a study of 336 males who had suffered at least one myocardial infarction, Sigler¹ reports that manual workers showed the lowest percentage of patients returning to work, compared to clerical workers, business and professional men. The author notes that in many cases the mere apprehension that "return to work would shorten life prevents the patient from resuming activities." It is also well known that emotional disturbance is probably the most common cause of cardiac disability in postinfarction cases.¹

The anxiety factor in both *coronary* and *precoronary* patients has recently been discussed by Thomas,² who suggests: "Intensive investigation of the sources and kinds of anxiety, and how destructive forms of anxiety can be identified and relieved may be the next important step in the prevention of coronary heart disease."

Relief of anxiety with Librium® (chlordiazepoxide HCl) often proves a valuable adjunct to medical counsel, reassurance and the total management program; may help prevent the postcoronary patient from regressing into a state of invalidism.

As an adjunct in cardiovascular therapy, Librium® (chlordiazepoxide HCl): Quickly relieves anxiety of mild to severe degree in most cases. Helps expedite cooperation in therapeutic regimen. May be used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, antihypertensive agents

and diuretics. By relieving anxiety, helps encourage productive activities. Has a wide margin of safety and, in proper maintenance dosage, seldom impairs mental acuity or ability to function. Often effective in extended therapy, usually without diminution of effect or need for increase in dosage—in protracted use, periodic blood counts and liver function tests are advisable.

References: 1. Sigler, L. H.: *Geriatrics*, 22:(9) 97, 1967. 2. Thomas, C. B.: *Johns Hopkins Med. J.*, 122:69, 1968.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating

drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Doctors Launch Counter Attack Against Charges By Committee

Doctors across the country are launching counter-attacks against a "smear campaign from Washington," President Cannady stated recently before the American Business Club.

He added that social planners in Washington are plotting to ramrod "costly and inefficient" compulsory health insurance programs through Congress behind a smokescreen of public alarm.

Doctors, who want a "practical national health program," can no longer "stay above the battle when falsehood, distortion, evasion and innuendo" are used against them, he said. Citing examples, he answered the following charges in the recent Senate Finance Committee report on rising health care costs:

1. More than 4,300 doctors and 900 groups received \$25,000 or more under Medicare and Medicaid during the 1968-69 fiscal year.

"Many of these doctors work in low-income areas with the bulk of their practice made up of the elderly and public aid patients. Also the report cites only gross income figures. After expenses, a doctor gets only 38 cents from each dollar he earns.

"Of an estimated 200,000 doctors treating Medicare patients, only two have been convicted of fraud since the program began. That means well over 99.9% of our profession is honest. How many other professions can claim as much?"

2. Doctors bear a heavy share of the guilt for Medicare's financial dilemma.

"Although the American Medical Association in 1965 warned Medicare would cost at least \$4 billion a year, bureaucrats deliberately underestimated costs at \$2 billion to 'please patients as voters without scaring them as taxpayers.' Government figures show Medicare cost \$5.9 bil-

lion in 1968, with costs still rising."

3. Organized medicine itself is to blame for the doctor shortage.

"Medicare and Medicaid created an overwhelming demand for doctors' services without creating a single new physician. Instead, federal grants to medical schools emphasize research. While research is vital, training more doctors should have priority."

4. Soaring costs of Medicare and Medicaid are due to doctors increasing their fees.

"Doctors' fees under Medicare and Medicaid have been restricted since January 1, 1969, and still we get blamed for soaring costs.

"The government itself has admitted administration of federal health programs is 'inefficient and costly.'

"Proposals for further expansion of federal health insurance programs merit study, but the temptations must be measured against the health personnel shortage, staggering taxes and costs, political manipulations and general inefficiency."

Dr. Cannady also called for a study of a proposed AMA plan called Mediredit. Under Mediredit, low income groups would get graduated rebates on federal income taxes to buy private health insurance. Persons not earning enough to pay taxes would get insurance vouchers.

He said representatives of government, medicine and the public should, through mutual effort and trust, design a workable program guaranteeing high-quality health care at the lowest possible cost.

"We seek no running feud with critics in government, the press or elsewhere," Dr. Cannady noted. "On the contrary, we invite cooperation and mutual respect."

Government Without Tyranny

"The legitimate functions of government are two: One, to help one man help another man, two, to prevent one man from injuring another man. How this may be accomplished without tyranny is what political science is all about."—Jenkin Lloyd Jones, president, Chamber of Commerce of the United States.

DVR Asked to Say When on Pay Policy

ISMS Board members are pressing for an answer from DVR Director Alfred Slicer to specify when that department would begin paying physicians usual and customary fees. Mr. Slicer has told the ISMS Advisory Committee to DVR that his department favors such a payment policy but, because of budget restrictions, it would be impossible at the present time. Board members said that a definite target date should be announced by DVR.

Nursing Homes & ECF's Asked To Up Standards

The Illinois Department of Public Health was asked by ISMS to strengthen its minimum standards for nursing homes and ECF's by requiring the appointment of a medical director on a consulting basis. The request was made after the ISMS Council on Social and Medical Services reported some patients in nursing homes located a long distance from any physicians are being deprived of adequate medical care. The report said physicians in private practice are reluctant to continue treating such patients after transfer from hospitals. It was felt these patients would receive much better care if a physician's services were available on a consulting basis.

Medicare Will Change Wording

Continental Casualty Company (Medicare Part B carrier for most of the state) has agreed to stop using "medically not necessary" when notifying patients that medicare payments for certain services have been disallowed. Company representatives said they are also trying to change an HEW ruling that an MD may not bill for such disallowed visits after he has accepted assignment. ISMS told the Medicare representatives that more local medical judgment should be sought on doubtful cases before payment is denied.

YOUR INSURANCE QUESTIONS:

QUESTION: Does the ISMS Malpractice Insurance program provide protection after the death of the insured physician?

ANSWER: The assured's estate will be protected in the event of his demise to the limits of the policy.

Do you have a question of general interest on any ISMS-sponsored insurance program: Retirement Investment, Keogh, Group Disability, Group Major Medical, Professional Liability (Malpractice)? Send it to this column: "Your ISMS Insurance Questions," Illinois Medical Journal, 360 N. Michigan Avenue, Chicago, Ill. 60601. The column is a service of the ISMS Committee on Insurance.

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THE VIEW BOX

(Continued from page 340)

DIAGNOSIS: Extrapleural Hematoma as a result of a fracture of the second sternal segment.

On the PA chest the density is seen to obscure a portion of the left heart border but leave the aortic knob intact indicating its anterior location. On the lateral the density is seen to be elliptical in configuration and it is accompanied by a stripe which parallels the entire length of the sternum which is unusually wide. This should direct one's attention to the sternum and a careful observation demonstrates a small fracture of the anterior aspect of the second sternal segment. The history was then obtained that this patient had been beaten up while serving a prison sentence. The density gradually cleared in another three weeks and represents a collection of hematoma as the result of the injury described.

The President's Page

About Peer Review

(Continued from page 320)

Those of you who attended our February 8 Leadership Conference on Peer Review were told that county society people would be on the starting line and were urged to adopt local peer review committees patterned about the ISMS Guidelines.

I urge you to start a peer review program as quickly as possible. Time is of the essence. If we fumble our peer review opportunity, Washington is ready and eager to do it for us.

I'm sure you'll agree . . . this alternative is less than desirable.

Edward W. Cunnady

The National Society for the Prevention of Blindness recommends a vision test requirement for all seeking hunting licenses to help reduce the number of hunting accidents

Accident Statistics

Accidents caused an estimated 116,000 deaths in 1969, or approximately 1,000 more than in 1968, according to statisticians of Metropolitan Life Insurance Company. The provisional death rate in the year just ended was virtually the same as in 1968, when the figure was 57.5 per 100,000 population.

An increase in the death toll from motor vehicle accidents was in large part responsible for the rise in the loss of life from accidents during 1969. Motor vehicle fatalities increased by somewhat over 1,000 to 56,500 in 1969, a new high. Preliminary data indicate, however, that motor vehicle deaths rose less than the volume of travel. This produced a slightly lower death rate per 100 million vehicle miles traveled than the 5.5 recorded in 1968—the third successive decline in this annual figure.

Public accidents other than those involving motor vehicles also figured prominently

in the rise in the death toll from all accidents combined, with an increase to 21,500—about 1,000 over the figure for the previous year.

The number of job-related fatalities in 1969 was approximately 14,500, or about the same as in the previous year; about 3,300 of these deaths are included in the estimate of 56,500 motor vehicle fatalities mentioned above. The toll from injuries in and about the home declined to about 27,000, or by approximately 1,500 from the 1968 total.

A revision was made in the official method of classification of the *International List of Causes of Death* (Eighth Revision). The figures for 1968 and 1969 are not strictly comparable with those for earlier years. It is believed that the 1969 and 1968 estimated figures are somewhat higher than they will be when the official totals are published by the National Center for Health Statistics.

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Quackery Pamphlets Available

The American Medical Association has published a series of pamphlets to warn of the alleged "new remedies," "secret remedies" and other deceptive "treatments" which cost the public millions of dollars.

"Health Quackery—Arthritis," first of the series, states that arthritis sufferers, by the nature of their ailment, are vulnerable targets for the deceitful nostrum peddler and vicious health quack.

The booklet notes that about 13 million Americans say they suffer from arthritis, and that arthritis "costs the nation nearly \$2 billion each year in work lost, treatment expense, disability payments and other factors." The booklet also debunks devices which are peddled as cures, and "arthritis clinics" at spas which advertise a "drugless way" to end arthritis misery.

Second in the series, "Health Quackery—Devices" warns that the health machine quack falsely claims that he can diagnose and cure disease simply by the use of his machine or by selling or renting the device.

The pamphlet points out that "fraudulent devices supposed to 'treat' various diseases and ailments have ranged from simple copper bracelets to elaborate electronic devices." Among the devices discussed are the ozone generator which is claimed as a treatment for "about everything," including emotional problems; vibrators which are claimed to "cure" arthritis and rheumatism; air cleaners; and denture reliner and repair kits.

"Health Quackery—Chiropractic," third in the series, stresses that "chiropractic constitutes a hazard to rational health care in the United States because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease."

The pamphlet warns that "the delay of proper medical care caused by chiropractors and their opposition to the many scientific advances in modern medicine, such as life-saving vaccines, often ends with tragic results."

Copies of all three pamphlets are available from the Order Handling Department, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610 at 20¢ each; 18¢ each in lots of 50-99; 16¢ each in lots of 100-499; 14¢ each in lots of 500-999; and 12¢ each in lots of 1,000 or more.

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ABSTRACTS OF BOARD ACTIONS	483
CLINICAL ARTICLES	
Vaginal Surgery for Non-Malignant Gynecological Conditions	499
<i>A. F. Lash, M.D., Ph.D.</i>	
A Diphtheria Outbreak in Chicago	
<i>Charles A. Kallick, M.D., George F. Brooks, M.D.,</i> <i>Arthur S. Dover, M.D., Murray C. Brown, M.D., and</i> <i>Olga Brolnitsky, M.D.</i>	505
Functional Interpretation of Placental Ultrastructure	523
<i>Ralph M. Wynn, M.D.</i>	
Sex Chromosome Abnormalities and Neuropsychiatric Disorders	528
<i>Janet D. Rowley, M.D.</i>	
SURGICAL GRAND ROUNDS	
Pelvic Trauma	513
MEDICAL PROGRESS	
Therapy for AHF and PTC Hemophilia, Part I	518
<i>Ruth Andrea Seeler, M.D.</i>	
SPECIAL ARTICLE	
Medical Services in South Africa	532
<i>Harold C. Voris, M.D.</i>	
FEATURES	
The President's Page	489
New Pharmaceutical Specialties	490
Meeting Memos	512
The View Box	522
Obituaries	537
The Doctor's Library	538
Clinics for Crippled Children	539
Socio-Economic News	545
Editorials	551
Physicians Placement Service	554
Membership Forum	555
Public Affairs Library	555

(Cover story on page 492)

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BLUE SHIELD REPORT



FOR *Illinois Physicians*

Summary of Annual Report, 1969

Like every viable business, an enterprise such as the Blue Shield Medical-Surgical Plan of Illinois Medical Service must function efficiently, constantly seek ways to improve its services and keep its costs under strict and manageable control. In 1969, Blue Shield's major emphasis has been on programs designed to meet these objectives.

Blue Shield enrolled its 2½ millionth member in 1969. At the same time, the Plan was faced with 150,000 more claims than it had handled in the previous year. Nevertheless, Blue Shield closed the year with an addition to reserves of \$894,542 against future medical-surgical expenses.

Among new programs given impetus in 1969, one which we refer to as "Usual and Customary" has received wide acceptance and approval. Offered as part of a comprehensive program both to group and non-group participants for the first time in 1969, this excellent health care feature provides 100% or 80%—under certain programs—payment of a physician's usual fee provided it does not exceed that customarily charged by other physicians of similar training and experience in the same area. Another was an expanded program of benefits now available to out-patients.

Equally important to everyone concerned with costs and their control were Utilization Review Committees, which are established to determine the need for and length of hospitalization, and Peer Review Committees, which provide a fair and impartial mechanism for adjudication in areas under dispute. Both programs are administered and carried out by the medical profession.

But this is not the whole story. For in this year, Blue Shield moved to accept new roles and responsibilities. These included continued administration of the medical-surgical portion of Medicare in metropolitan Chicago and together with Blue Cross, establishing a new Community Affairs Department created to help in all matters of public health, from

alerting young people to the dangers of drug abuse to health studies for Chicago's Model Cities Program.

Looking back over the year, 1969 has been challenging and productive. Steps have been taken to increase both our efficiency and our services. In all areas where it is possible for us to exert influence, we have established new programs for the control of costs.

We aren't satisfied. Not for one moment do we think we have solved all problems. The accomplishments of 1969 are but a beginning. We pledge a continuing concern and ever better health care service in the coming year. And with your good will, in all the years that follow.

Robert M. Redinger
Executive Vice President

FEP Enrollment Hits New High

Blue Shield and Blue Cross Plans now cover slightly over 60 per cent of all government workers in the Federal Employees Program (FEP) as a result of the recently concluded FEP "open season."

There was a net gain of over 100,000 contracts.

During the last FEP open season in 1966, Blue Shield Plans gained 27,253 new contracts.

With 98 per cent of the results now in, Blue Shield Plans have established a 6.6 per cent increase in total contracts during the November 1969 campaign. During the previous open season, in 1966, there was a 2 per cent increase.

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Services in Extended Care Facilities

Misunderstandings still exist over some Medicare exclusions contained in the law which have resulted in disallowed claims submitted by the physician, his patient, and by hospitals, extended care facilities, and home health agencies. In our effort to clarify the misunderstandings, this material is being written for Illinois physicians with the understanding that only the attending physician orders all the services his patient receives.

By reminding physicians of covered services paid for by Medicare, they will be in a better position to advise their patients that some services may not be covered so that their patients can anticipate alternative arrangements for payments to be made.

Non-covered services which include cosmetic surgery, routine foot care, dental care, and routine check-ups are well understood by most physicians. However, custodial care, frequently misunderstood, is defined as "care designed essentially to assist an individual to meet his activities of daily living—i.e., services which constitute personal care such as help in walking and getting in and out of bed, assistance in bathing, dressing, feeding and using the toilet, preparation of special diets, and supervision of medication which can usually be self-administered—and which does not entail or require the continuing attention of trained medical or paramedical personnel." When the patient's condition is such that it medically justifies continuous Skilled Nursing Services and the need for such services constitutes the primary purpose of the total care furnished, he is receiving a level of care which is covered by Medicare.

Definition of Skilled Nursing Services:

Skilled Nursing Services are defined by the Social Security Administration as services "which must be furnished by or under the supervision of trained medical or paramedical personnel to assure the safety of the patient and achieve the medically desired result. A service is not classified as skilled merely because it is performed by a trained medical or paramedical person. A service which can be safely and adequately self-administered or performed by the average, rational, non-medical person, without the direct supervision of trained medical or paramedical personnel, is a non-skilled service without regard to who actually provides the services." Neither the importance of a

particular service to an individual patient nor the possibility of adverse effects from improper performance of an otherwise unskilled service, will change the nature of a service from unskilled to skilled. For example, giving oral medications, changing positions of non-ambulatory patients, transfer of patients from bed to wheel chair are not considered skilled services. Any generally unskilled service could, because of special medical complications in an individual case, require skilled performance, supervision or observation. However, the complications and special services involved should be documented by nursing notes and/or physician orders. Recording may include the observations made of physical findings, new developments in the course of the disease, the carrying out of details of treatment prescribed, and the results of the treatment.

Extended Care Facilities:

Services in extended care facilities are provided by the Medicare law to serve as a more economical alternative for continuing care that was begun in the hospital. It represents an EXTENSION of inpatient hospital care and implies an earlier discharge than otherwise might have been achieved. The Medicare statute imposes the following requirements for coverage of inpatient services in an extended care facility.

1. The beneficiary must have been an inpatient of a hospital for at least 3 consecutive calendar days; and
2. The beneficiary must have been transferred to the extended care facility within 14 days after discharge from the hospital; and
3. The services must be required for treatment of a condition or conditions with respect to which the beneficiary was receiving inpatient hospital services prior to transfer to the facility or for a condition which arose while receiving extended care for treatment of a condition or conditions for which he was receiving inpatient hospital services; and
4. The condition or conditions must require skilled nursing care on a continuing basis; and
5. A physician must certify (and recertify where the services are provided over a period of time) that requirements 3 and 4 are met.

Independent Laboratory Clarified

To clarify the definition of an independent laboratory published in the April, 1970, issue of this report, the Social Security Administration classifies an independent laboratory as one "which is independent both of the attending or consulting physician's office and of a hospital which meets the conditions of participation in the program."

An approved independent clinical laboratory, according to the Social Security Administration, is one "which is approved by the Secretary of Health, Education, and Welfare as meeting the specified conditions for coverage under the program."

Abstracts Of Board Actions

Board of Trustees Meeting
March 7-8, 1970
Ambassador West, Chicago

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

State Hearings on Medical Costs and Utilization

The state of Illinois has joined numerous others in studying the problems of health care delivery, according to the report of the President, Dr. Edward W. Cannady. ISMS representatives appeared before the Advisory Committee on Medical Costs and Utilization of Services in February. The Committee, established by the General Assembly last spring, is due to report its findings in April. Legislation to control hospital expansions or attempts to establish a public utility status for hospitals, may be in the offing. Dr. Cannady called for completion of the investigation of those Illinois physicians who received more than \$25,000 from IDPA in 1968.

Program 1970-71

President-Elect, Dr. J. Ernest Breed, outlined his proposed program for 1970-71. During his term as president, four major items will be stressed: Continuing Education, Peer Review, Malpractice, Changes in Delivery of Medical Care.

Membership Increases

A review of the 1969 membership by Dr. Jacob Reisch, Secretary-Treasurer, showed a slight increase in membership. Early membership data reflects a greater rate of increase for 1970.

Medically Not Necessary

The Executive Committee reported on an agreement with the Medicare Division of Continental Casualty Company to delete the phrase "Medically not necessary" when notifying patients that payment is being disallowed under Medicare. Further effort is being made to change the Medicare ruling that a physician may not bill for disallowed visits if an assignment has been accepted.

Commenting on the February 12, meeting with Continental Casualty officials the report said, "Your representatives let it be known that we felt the Medical Department of Continental often acted in an arbitrary fashion and that more local medical judgment should be sought on doubtful cases, before payment is denied."

Malpractice Screening Panel

A report of the Ad Hoc Committee indicated a lack of approval from the Bar Association on the formation of a joint screening panel to evaluate malpractice cases. Approval in principle was given for the Committee to proceed unilaterally in the develop-

ment of a screening committee composed of physicians only. The overall plan includes the provision of expert medical testimony to aid in the defense of cases where no liability is judged to exist and an educational campaign to teach physicians how to avoid malpractice suits.

The Committee will develop an exhibit and sponsor a program on malpractice at the Annual Meeting. The name of the committee was changed to Physician's Liability Evaluating Committee.

Journalism Awards Dinner

The Board of Trustees hosted a dinner honoring the 1969 Journalism Awards winners. This was the sixth annual awards presentation with over 210 entries submitted. Board Chairman, Frank J. Jirka, Jr., M.D., inducted three of the winners into the Medical Journalism Hall of Fame; Don Wooten, WHBF-TV, Rock Island; Art Snider, the Chicago Daily News; and Ron Kotulak, the Chicago Tribune.

State Funds Requests for Medical Education Cut

Funds approved by the Commission on Health Education for expanding medical enrollment and health related programs were slashed approximately one-half by the staff of the Board of Higher Education in the preparation of the Governor's budget, according to the report of Dr. Philip Thomsen. For example, the \$17.2 million approved by the Commission for medical and dental education, nursing and allied health services for the non-public institutions, was cut to \$8 million. Funds earmarked at the University of Illinois and Southern Illinois University for expansion programs in medical education were also drastically cut.

Following vigorous protest by ISMS, the Health Education Commission and the medical schools, the Board of Education overruled the staff and restored a substantial portion of these funds in a supplemental recommendation. However, failure of those amounts to be included in the Governor's budget will require special action by the General Assembly in the April budgetary session to restore these funds. The high-handed action by the Board of Higher Education staff poses a threat to the time-table which the Commission on Health Education has been able to establish with the medical schools for doubling the medical school enrollment.

Cook County Hospital Commission

Dr. Philip Thomsen, a member of the County Hospitals Governing Commission, reported on the critical shortage of house staff, and other problems confronting Cook County Hospital. Among other things, the Commission finds itself handicapped by personnel and budgetary restrictions laid down by the Cook County Board and plans to seek amendments to the Enabling Act which created the Commission, to give it more autonomy in operating the hospital. The Commission also has jurisdiction over Oak Forest Hospital. By official action, the Board went on record as supporting legislation to free the Commission from the controls exercised by the County Board.

(Continued on page 559)



Edward W. Cannady, M.D.

The President's Page

Remember Mr. Cohen?

Do you remember Wilbur Cohen?

He's the former secretary of the U.S. Department of Health, Education and Welfare.

During the early 1960's Mr. Cohen and his friends were beating the drums for Medicare—and they played to a full house. It was a popular tune—guaranteed health care for everyone 65 and over—all this for only \$2 billion a year.

We doctors warned it would cost at least twice that much. In fiscal 1968, Medicare cost \$5.3 billion. So we were right and Mr. Cohen was wrong.

But confession comes hard to bureaucrats. They'd rather find a whipping boy, and they have—us! They say we doctors are running up Medicare costs.

They're feeding the public a steady diet of half-truths, innuendoes, and out-and-out lies to undermine confidence in the medical profession.

Hidden behind the controversy, social dreamers plan to soft-sell the public on a compulsory national health insurance program.

A recent story in the Wall Street Journal tells about the "Committee for National Health Insurance," a strong lobbying group in Washington.

Acting as a consultant to the group is the omnipresent Mr. Cohen—and he's playing a familiar tune. According to Mr. Cohen, adoption of a compulsory national health insurance program is "only a matter of time."

Even the Senate Finance Committee admitted the administration of Medicare and Medicaid is "erratic, inefficient and costly," but Mr. Cohen and his friends want to compound the costs by including the entire population in a cradle-to-grave bureaucratic nightmare. It's like prescribing cancer to cure a heart attack!

In this—my last President's Page message—I implore all of you to help tell OUR side of the story.

Both the AMA and our state society have powerful ammunition available to assist you. You have already received some of the material, such as the "Medicare Facts" pamphlet.

Use them!

In our county medical societies we have powerful, influential local voices—if only we make them heard. It's up to each one of us to tell it like it is right in our own hometowns—to newspapers, radio and TV stations, civic and public groups, to anyone who will listen.

We can't ignore Mr. Cohen and his friends—not for a single minute. If the day ever comes when America gets socialized medicine, or even a watered-down version of it, that will be the saddest day in the history of American medicine.

So let's get mad—BOILING MAD—and do something about it!

Edward W. Cannady

**NEW
PHARMACEUTICAL
SPECIALTIES**

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

DUPLICATE SINGLE PRODUCTS

NILSTAT Fungicides-Systemic R

Manufacturer: Lederle

Nonproprietary Name: Nystatin

Indications: Prevention and treatment of infections caused by *Candida* (*Monilia*) *albicans*.

Contraindications: History of hypersensitivity to nystatin.

Dosage: 1 or 2 tablets t.i.d.

Supplied: Tablets, 500,000 units.

RENOGRAFIN-DIP Diagnostics-Contrast

Media

Manufacturer: Squibb

Nonproprietary Name: Meglumine Diatrizoate

Indications: Drip infusion pyelography.

Contraindications: Hypersensitivity to salts of diatrizoic acid. Urography is contraindicated in patients with anuria.

Dosage: i.v., continuous infusion

2 cc/lb. over a period of 8 minutes or longer.

Supplied: Vials, 300 cc.

TESTATE Hormones-Androgens R

Manufacturer: Savage

Nonproprietary Name: Testosterone Enanthate (NF)

Indications: Androgen therapy

Contraindications: History of prostatic carcinoma

Dosage: i.m.—individualized

Supplied: Vials, 10 cc-100 and 200 mg./cc.

TOTACILLIN Penicillin & Derivatives R

Manufacturer: Beecham

Nonproprietary Name: Ampicillin trihydrate

Indications: Infections due to susceptible strains of Gram negative and Gram positive bacteria.

Contraindications: History of allergic reactions to penicillins. Infections caused by penicillinase-producing staphylococci or other penicillinase producing agents.

Dosage: Adults 250–500 mg./6 hrs.

Children: 50-100 mg./kg./day in divided doses every 6-8 hrs.

Supplied: Capsules, 250 and 500 mg.

TOTACILLIN-N Penicillin & Derivatives R

Manufacturer: Beecham

Nonproprietary Name: Ampicillin sodium

Indications: Infections due to susceptible strains of Gram negative and Gram positive bacteria.

Contraindications: History of allergic reactions to penicillins. Infections caused by penicillinase-producing staphylococci or other penicillinase producing agents.

Dosage: i.m. or i.v.

Adults: 250-500 mg./6 hrs.

Children: 12.5 mg./kg./6 hrs.

Supplied: Vials, 125, 250, 500 and 1,000 mg.

COMBINATION PRODUCTS

DECONAMINE Capsules Cold Preparations-

Antihistamines

R

Manufacturer: Smith, Miller & Patch

Composition: Chlorpheniramine maleate 8 mg.
d-Pseudoephedrine HCl 120 mg.

Indications: Relief of upper respiratory and bronchial congestion.

Contraindications: Sensitivity to antihistamines or sympathomimetic agents; severe hypertension or coronary artery disease. Do not give to children under 12.

Dosage: One capsule every 12 hrs.

Supplied: Capsules.

DUOVENT Bronchodilator R

Manufacturer: Riker

Composition: Theophylline 130 mg.
Ephedrine HCl 24 mg.
Phenobarbital 8 mg.
Glyceryl guaiacolate 100 mg.

Indications: Symptomatic relief of bronchial asthma, chronic bronchitis and pulmonary emphysema.

Contraindications: Porphyria or known sensitivity to any of the ingredients.

Dosage: Adults: 1 to 2 tablets q.i.d.

Children (6-12 yrs.): ½ tablet t.i.d.

Supplied: Tablets

NIFEREX-F.A. Hematinic/Vitamins

Combinations

R

Manufacturer: Central

Composition: Iron 25 mg.
Folic acid 1.25 mg.
Ascorbic acid 125 mg.
Cyanocobalamin 2.5 mcg.
Calcium carbonate 312 mg.

Indications: Vitamin and mineral therapy

Contraindications: None mentioned

Supplied: Tablets, film coated

NIFEREX Prenatal Vitamins-Prenatal R

Manufacturer: Central

Composition: Iron 40 mg.
Folic acid 1.25 mg.
Ascorbic acid 50 mg.
Cyanocobalamin 3 mcg.
Vitamin A 4000 USP units
Vitamin D₂ 400 USP units
Thiamine mononitrate 3 mg.
Riboflavin 3 mg.
Pyridoxine HCl 2 mg.
Niacinamide 10 mg.
Calcium carbonate 312 mg.

Indications: Prenatal vitamins

Contraindications: None mentioned

Supplied: Tablets, film coated

ORNEX Cold Preparation-General o-t-c

Manufacturer: Smith Kline & French

Composition: Acetaminophen 175 mg.
Salicylamide 150 mg.
Caffeine 15 mg.
Phenylpropanolamine HCl 18 mg.

Indications: Symptomatic relief of sinusitis, the common cold and influenza.

Contraindications: Should not be used in patients taking MAO inhibitors.

Dosage: Adults: 2 capsules every 4 hrs.

Children (6-12 years): 1 capsule every four hours.

Supplied: Capsules

(Continued on page 564)

A REMINDER

*Today
(or any other day)
you probably
have use for*

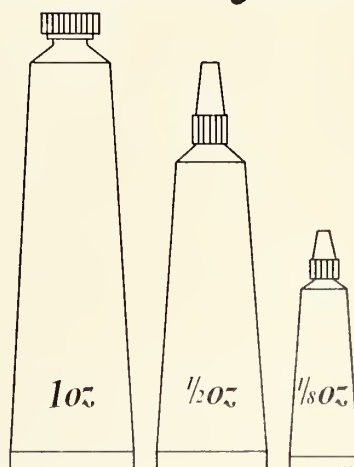
Neosporin[®] Ointment

Polymyxin B/Bacitracin/Neomycin

each gram contains

<i>Aerosporin[®] brand Polymyxin B Sulfate</i>	<i>5,000 units</i>
<i>Zinc Bacitracin</i>	<i>400 units</i>
<i>Neomycin Sulfate</i>	<i>5 mg.</i>
<i>(equivalent to 3.5 mg. Neomycin Base)</i>	
<i>Special White Petrolatum</i>	<i>q.s.</i>

*Complete literature available on request
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BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.

Creating Dizziness To Cure Dizziness

Physicians at Northwestern University's new Dizziness Clinic have found they can best help the sufferer of severe dizziness if they first make him dizzy again.

"In the Clinic, we perform a battery of procedures to recreate the many types of dizziness which can occur," explained Dr. David A. Drachman, Clinic director.

"For example, we spin the patient around in a rotating chair, make his blood pressure drop suddenly, and make him stand independently in a dark room to see if he can maintain his balance. Patients refer to so many different phenomena as 'dizziness' that the first step in diagnosis must be to understand the precise nature of each patient's sensation.

"Dizziness is a symptom, not a disease," Dr. Drachman said, "and it can be caused by hundreds of factors. Before we began our Dizziness Clinic, there was no single place a dizzy patient could go for a comprehensive work-up which crossed all lines of medical specialties."

Most doctors and clinics in the country studying dizzy patients work only with those who experience the spinning sensation of vertigo. At Northwestern, however, patients who have *any* of the four possible types of dizziness—vertigo, faintness, loss of balance, or ill-defined "lightheadedness"—are accepted for detailed investigation.

In addition to simulating the various types of dizziness, the Northwestern approach includes a thorough history, complete physical, neurological work-up, ear-nose-throat work-up, and extensive lab tests. The entire exam is quite costly and takes a minimum of four half-days to complete.

Dr. Drachman emphasized that the

Clinic was designed to contribute to research being done at Northwestern in diagnosing and improving treatment of dizziness and to handle patients with prolonged, disabling dizzy spells.

"We are all dizzy occasionally," he noted, "and many patients suffer from forms of dizziness that are easily diagnosed. In the Dizziness Clinic, we see primarily the special patients who suffer from hard-to-describe, hard-to-pinpoint conditions which have previously remained mysteries."

A Standard Dizziness Exam

Through the clinical research which the Clinic has done over the past year, Dr. Drachman hopes to evolve a simplified dizziness examination which could help doctors in every specialty to handle their dizzy patients better.

Computers are playing a large role in achieving this goal. The forms which the examining physician must complete on each patient are designed for computer use. Patient data is thus analyzed and sorted as the Clinic operates.

Eventually, the computer should arrive at the 10 most common causes of dizziness as well as the most relevant questions and procedures for diagnosis. This information could then be distributed to doctors in all specialties to be used as a guideline in their office examinations.

In the future, Dr. Drachman can even visualize the sequence of each patient's exam being planned by a computer. "If we can gather enough data to program the computer with an appropriate series of questions, it could help greatly in providing short cuts to arrive at an accurate and fast diagnosis," he said.

ON THE COVER

May is "Poppy Month" in Illinois—a time in which the Veterans remind us of Flanders Field, World War I, battlefield and groveyard, where the U.S. suffered a severe casualty loss amid a field of poppies. This "flower of remembrance" now serves as therapeutic treatment for patients in Veterans Hospitals, who smoke them. Proceeds from the sale of the poppies go for rehabilitative work for veterans in and out of hospitals.

In another light, the poppy is a medicinal herb, the most common known—the opium poppy.

The girth control pill



Tepanil[®] Ten-tab[®] (continuous release form) (diethylpropion hydrochloride)

works on the appetite
not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety,

and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in mid-evening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,001,910



THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Esophagus Involved In Lab Studies

The source of heartburn and other common afflictions is the esophagus, the tube that carries food from the mouth to the stomach. One out of every four adults, for example, has a hiatal hernia—often the cause of chronic heartburn.

An unusual laboratory to study the esophagus has just been established at the Northwestern University Medical School and Passavant Memorial Hospital.

According to Dr. Marshall Sparberg, director of the Esophagus Laboratory and of the Gastroenterology Clinic at the Medical School, "Ours may be the first laboratory anywhere devoted exclusively to the study of the esophagus. It has been a relatively neglected area of the digestive tract, partly because of the specialized equipment required to study it comprehensively. We now will be able to examine all disorders of the esophagus, concentrating particularly on heartburn, difficulty swallowing, regurgitation, cancer, and some types of undiagnosed chest pain."

Unlike the usual conception of medical laboratories, this one will not contain test tubes and chemicals. Instead, it will consist of the most modern and comprehensive equipment known for the diagnosis and treatment of esophageal disorders.

"In addition, the Laboratory will be able to complete a patient's work-up in one morning, eliminating the need for a two or three-day hospitalization period for tests."

The Lab will be equipped with a new instrument that can literally "see around corners" and will be available to look inside the esophagus for signs of cancer or inflammation. "The flexible nature of the instrument not only allows a better view of the esophagus," Dr. Sparberg emphasized, "but also provides much more patient comfort and safety."

The Jules J. Reingold Trust has funded the Laboratory for the next three years to foster better diagnosis and treatment of esophageal problems.

The Lab has already completed a research project analyzing the relation of rheumatoid arthritis to swallowing problems, with certain related disorders producing severe swallowing difficulties. Currently, a new drug for the relief of heartburn is being studied by the Laboratory.

Brief Summary of Prescribing Information—9-9/22/69. For complete information consult Official Package Circular.

Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.

Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or *bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)

Usual Dose: 1 tablet b.i.d.

Supplied: Bottles of 60, 600, and 1000 scored 50 mg. tablets.

Salutensin®
hydroflumethiazide, 50 mg./reserpine,
0.125 mg. protoveratrine A, 0.2 mg.

BRISTOL

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Syracuse, New York 13201

Vaginal Surgery

For Non-Malignant Gynecological Conditions

A. F. LASH, M.D., PH.D./CHICAGO

The current concepts of vaginal surgery are that diagnostic and therapeutic procedures may safely and adequately be performed on the pelvic organs via the vaginal route. The advantages are that there is less postoperative discomfort and shorter postoperative hospital stay. The necessity for exploratory laparotomy has decreased with the increase of diagnostic capabilities based on more adequate laboratory data (i.e. roentgen and biochemical). The vaginal diagnostic surgical procedures such as colpocentesis, posterior colpotomy, biopsy and curettage are so well established and generally practiced, they require no further exposition.

The exploratory posterior colpotomy in our hands has proved more satisfactory for diagnosis than culdoscopy or peritoneoscopy. Increased exposure of the pelvic cavity can be achieved by the temporary section of the uterosacral ligaments. Therapeutic procedures may also be performed such as salpingectomy for unruptured ectopic pregnancy, or for sterilization, partial or complete oophorectomy for polycystic ovaries or bleeding corpus luteum or follicle cysts.

The therapeutic measures, vaginal hysterectomy, anterior and posterior colporrhaphy, vaginal vault herniorrhaphy and reconstructive vaginal surgery warrant continued discussion because the problems

they aim to resolve are still current although they have been dealt with for a long time. Surgical anatomical experience and clinical followup serve as the basis for the elaboration of these concepts rather than cadaver anatomical studies. However, to be complete, a historical review is in order and then an evaluation of the various other vaginal operations which have been tried and abandoned. Also, the challenging facet of vaginal reconstructive surgery, has been the failures, and their management.

History of Vaginal Surgery

Medical history not only contributes to our knowledge of the genesis of surgical procedures but also relates the difficulties and disappointments associated with the development of these operations. Perhaps the errors and pitfalls which confronted them may be avoided by us.

The earliest written reference to gynecology is found in the Papyrus Ebers (1550 B.C.) which mentions remedies for the woman to replace her prolapsed uterus.^{4,7,9}

The description of a very large vagina in the ancient Hindu⁷ (1200-1000 B.C.) medicine may be interpreted to mean cystocele, rectocele and lacerated perineum.

Greek medicine⁷ (430 B.C.) during the Hippocratic period⁶ describes the succussion method for the treatment of irreducible prolapse and the use of medicated pessaries and tampons.

Soranus in Rome⁷ (98-138 A.D.) sug-

**This paper was presented at the 129th Annual Meeting of the Illinois State Medical Society, May 18-21, 1969.*

gested a surgical procedure only when the uterus itself was gangrenous and stated that it could be done without endangering the patient's life.

A. Benedetti^{4,9} (1497) was the first person to use the word "procidentia" in describing genital organ prolapse.

In 1521, J. Berengario da Carpi^{4,9} placed a stout twine around the prolapsed uterus, which was gradually tightened over a period of days until the organ was severed. The stump was treated with a mixture of wine, honey and aloes.

Pare,^{4,9} late in the 16th century, described early vaginal surgery, in repairing the perineum following severe traumatic childbirth.

About 1670, Johan Peyer,^{4,9} a Swiss gynecologist made the first reference to the bladder as a prolapsed viscus and recorded the first true description of cystocele. He also believed that both the uterus and the bladder could prolapse under certain circumstances. Von Ruysch published in 1691 the first illustration of uterine prolapse which truly represented the organs involved in such relaxations.

In 1702, B. Saviord^{4,9} attempted to differentiate between a prolapse and an inversion of the uterus. R. J. C. De Garengeat,⁹ in 1737, used the term "enterocele vaginale" which was the first use of the term enterocele in relation to vaginal relaxation. The anatomy of the vagina and its surrounding structures were described by him. Further anatomical description was followed by D. Santorini⁹ in 1739 and others.

The first operation recorded for the evacuation of a tubo-ovarian abscess was performed by L. Aumauier^{4,7} of Rouen in 1776.

Vesicovaginal and rectovaginal fistulas received considerable attention, mainly because they were so common, with only occasional treatment attempted. The use of indwelling catheters and the insertion

of innumerable pessaries of gold, silver, wax and wood to fill the vagina and close the aperture were ineffectual.

Following these clinical descriptions and anatomical studies, terminology was established with the onset of the nineteenth century, and classification of various pelvic relaxations was described as used today. During this century (19th) surgical techniques, improvement of suture material, creation of surgical instruments, anesthesia and antisepsis combined to contribute to the development of the numerous operations for the correction of prolapse of the genital organs.

Osiander, in 1806,⁹ amputated the cervix afflicted with carcinoma. In 1813, C. J. N. Langenbeck⁹ (Germany) performed a vaginal hysterectomy which was also done by Sauter⁸ (France) in 1822 and J. Blundell⁹ (England) in 1829. The first vaginal hysterectomy in the United States has been attributed to J. C. Warren⁹ (1829) in Boston. V. Czerny,⁹ in 1878, developed the basic principles of the operation which are followed today.

Recamier (1774-1852)⁹ introduced the vaginal speculum, the uterine sound, and curette.

L. Le Fort⁹ in 1877 and Neugebauer in 1881 described and popularized the denudation procedures of the vaginal mucosa for prolapse of the uterus. A. Donald⁹ of Manchester, England, in 1888, combined anterior and posterior vaginal repairs, perineorrhaphy and cervical amputation. W. Fothergill⁹ modified these procedures and reported in 1908 the utilization of the cardinal ligaments for supporting the uterus. This operation is used today in women in the childbearing age in this country while in England and Australia it is performed for prolapsed uterus in all ages.

In 1888, A. Mackenrodt⁹ and in 1894, A. Duhrssen⁹ described vaginofixation operations. There followed a series of modifications by other operators.

The interposition operations followed: Freund,⁹ in 1895, brought the uterus into the vagina and sutured it in situ. Vineburg and Wertheim,⁹ in 1896, shortened the round ligaments vaginally in a modified type of vaginofixation which led to the "interposition operation." Schauta (1909), Wertheim (of Vienna) and Watkins^{4,9} (of Chicago) described similar procedures and

Abraham F. Lash, M.D., is Director, Division of Obstetrics and Gynecology, Cook County Hospital. He is a graduate of Rush Medical College and also received his Ph.D. from the University of Illinois. Dr. Lash is professor emeritus of the Northwestern University Medical School.



their names were attached to the operation.

Emmett,^{4,9} of New York, developed the best operative technique for rectocele repair.

The composite operation for prolapse of the uterus was introduced by A. B. Spaulding^{4,9} (Baltimore) in 1919 and E. H. Richardson^{4,9} (Baltimore) in 1937. R. Te Linde¹² champions this procedure, in which the cervix is amputated followed by a supravaginal hysterectomy, thus preserving the cervical isthmus as a point of support in the pelvis.

Vesicovaginal fistula had been a problem for countless generations, but it was always considered too formidable and discouraging to be given more than sympathy or an occasional attempt at closure. Many attempts were made but with little success, and it was not until 1852, when James Marion Sims^{4,9} published his epochal work which established the principles for successful results.

Howard A. Kelly,^{4,9} in 1912, introduced a vaginal procedure for correcting urinary incontinence, and although universally used, failures occurred. In 1924, Gersuny⁹ described the urethral torsion (180 degrees) operation which also stretched the urethra under the symphysis pubis and supported it by the dissected pyramidalis muscles. Stress incontinence is still a problem and other operations suggested are the Berkow,⁹ Ingelman-Sunberg,⁹ Marshall-Marchetti,⁹ Lapidus⁹ and the sling operations of Aldridge-Studdiford⁸ or Millen.⁸

Vaginal Surgery

The vaginal surgical procedures to be considered are: vaginal hysterectomy, cystocele repair, anterior colporrhaphy, rectocele repair, perineorrhaphy and vaginal vault herniorrhaphy.

Vaginal hysterectomy^{3,6} is performed more frequently today and has been utilized for prolapse of the uterus, which formerly was treated by combined operations such as vaginal plastic and abdominal hysterectomy, interposition, suspension procedures, Spaulding-Richardson operation, Donald-Fothergill, or Manchester procedure (in Great Britain and Australia, the Manchester procedure is still favored). Baer² and his associates have reported in 1937 the trend in the treatment of vaginal prolapse by vaginal hysterectomy. By 1951,⁵ at Cook County Hospital, comparing the

five year period of 1926-30 with the period of 1943-47, the incidence of vaginal hysterectomy increased from 158 to 531 while the mortality decreased from 1.9% to 0.75%. During these same periods, the suspension operations decreased from 535 to 60, and Watkins-Wertheim interposition operation dropped from 21-0. The statistics from public institutions, as Cook County Hospital, vary from that of private service hospitals because of the difference in the character of the pathology. In the former, pelvic inflammatory and neoplastic diseases are dominant, while in the latter, prolapse of the uterus, relaxations, and hernias prevail.

In a personal series of 2,007 vaginal hysterectomies, the private (1,516) group accounted for three times as many as those performed at Cook County Hospital (491) over a similar period of 27 years. In 75% of instances, menometrorrhagia due to various causes was the chief symptom. While in 18.4% of the patients, pressure suprapubically or in the vagina plus the awareness of a vaginal mass or protrusion was the next chief symptom. Our own indications have extended to include the following: Stage-O Carcinoma of the cervix, Stage-I adenocarcinoma of the endometrium, therapeutic abortion and sterilization in addition to the usual fibroids uteri (up to 16-18 weeks in size) with or without pregnancy, adenomyosis, and prolapse of the uterus. Vaginal hysterectomy is a flexible procedure,¹ in that if associated pathology is found unexpectedly, no harm follows if the pathology is then approached abdominally. It also allows for a greater margin of safety in poor risk and elderly patients.⁸ Vaginal surgery lends itself to pudendal and paracervical local anesthesia (incidence 7.5%), particularly in elderly women. In 52% of instances one or both adnexa were removed. Anterior and/or posterior vaginal plastics were also performed in 33.5% of patients. The morbidity has dropped from 38% to about 10% with the use of preoperative vaginal antiseptic douches and antibacterial vaginal suppositories.

There were six deaths in the private series of 1,516 vaginal hysterectomies (0.38%). One patient (48 years) died 20 hours postoperative; she was markedly depressed by her preoperative medication

and had a combination of cyclopropane-ethylene anesthesia—the cyclopropane was not to have been used since 0.5 cc of pituitrin was injected into the cervix. The only significant autopsy finding was a small heart in a big woman. The second patient, 46 years of age, died 12 hours postoperative with pulmonary edema, and a large pheochromocytoma was found in the right adrenal gland. The third patient, 46-years-old, had a dilatation and curettage, vaginal hysterectomy, and bilateral salpingo-oophorectomy. On the eighth postoperative day she became weak on returning from the bathroom. She appeared pale and had a rapid pulse and hypotension. Late intraperitoneal bleeding was suspected, and exploratory laparotomy was thought necessary. There was a blood clot of about 100 cc and 3-400 cc bloody serum in the peritoneal cavity. Cardiac arrest suddenly occurred during the operation, and in spite of cardiac massage and stimulation, the patient died.

The fourth patient, a 45-year-old woman, had a vaginal hysterectomy and perineorrhaphy. Four and one-half hours later she went into deep shock and in spite of all measures died, which was considered to be due to hemorrhage—an inexperienced person was in attendance and was unable to evaluate the beginning of shock symptoms and to notify any of the medical personnel before the condition became irreversible.

The fifth patient, 45 years of age, died on the sixth postoperative day after a vaginal hysterectomy and right salpingo-oophorectomy from a coronary thrombosis. The sixth patient was 52-years of age with hypertension (220/110) and was treated medically for five days in the hospital in preparation for surgery for bleeding fibroids (12 weeks size). Ten days after a vaginal hysterectomy and posterior plastic she died from pelvic infection and uremia. Of this number, two deaths³⁻⁴ could be considered preventable.

It may also be noted in the private series of 1,516 vaginal hysterectomies, in over 55% of instances, one or both adnexa were removed. When ovaries are not removed because of the absence of gross pathology or age of the patient, it is most important for these women to be informed of the importance of routine interval (every six months) pelvic examination. A certain per-

centage, though small, may develop cysts of ovaries, hydrosalpinges, or both, and carcinoma of the ovaries.

Anterior and/or posterior vaginal plastic surgery was associated with the vaginal hysterectomy in about 35% of the patients. At all operations the depth of the cul-de-sac was evaluated, and the deep ones were obliterated by purse-string sutures between the uterosacral ligaments, or if a deep hernial type of sac was found, it was dissected out like any hernial sac and closed by double purse-string sutures with further support from the fascial tissue below the peritoneum. Prophylactic measures are therefore of greater value in anticipating and preventing enteroceles. In our series, there was an incidence of 0.85% (in the first 10 years) while practically none in the later years. Nonetheless, in older women, years after a hysterectomy (abdominal or vaginal), vaginal vault hernias may occur because of the atrophy of the pelvic fascias and the increased abdominal pressure secondary to the usual chronic constipation and pulmonary conditions (emphysema and asthma) commonly found in geriatric patients.

Vaginal vault hernia and/or cystocele occurred from one to 20 years post vaginal hysterectomy. It becomes obvious that prophylactic treatment is most effective.

The true hernia of the vaginal vault has become more common as there has been an increase in incidence of hysterectomies (abdominal and vaginal). Vaginal hysterectomy, in relation to prolapse of the uterus, is only part of the operation and the restoration of the urogenital diaphragm and the pelvic floor are essential to the support of the vagina. In the course of studying vaginal vault hernias,⁹ we have carried out roentgenological studies which demonstrate the importance of following the principles of herniorrhaphy as in inguinal femoral, umbilical, or diaphragmatic hernias.

In the course of performing vaginal surgery in geriatric patients,⁸ the merit of local anesthesia has not been emphasized sufficiently. In the series under discussion, about 10% were in the geriatric group. With properly adjusted preoperative medication (controlled by age—barbiturate, demerol and scopolamine), pudendal and paracervical block with 1/2% xylocaine, any vaginal surgery from vulvectomy, col-

pectomy, vaginal hysterectomy with anterior and posterior colporrhaphy, may be readily executed. The patients tolerate the procedures well and can be ambulated as soon as they are awake from the sedation. Thereby, there is no interference with their normal activities or functions. It is common knowledge that these elderly ladies are very independent and do not like to be restricted in their daily routine.

Complications and Failures

Low grade vault infections occurred in about 35% of the postoperative patients before the use of antibacterial vaginal suppositories and about 7-10% after their introduction. As a rule, mere digital separation of the vaginal edges was sufficient to allow for drainage and prompt healing. No serious infection or pelvic abscess development occurred. The vaginal vault being kept partially open (center 2cm) with an iodoform vaginal gauze for 48 hours, prevented the accumulation of serum, blood which may encourage secondary infection. Today, infections are not the problem as formerly.

Hemorrhage, immediate and late, still concerns us. The inadequately ligated pedicle containing the vessels or the slipped ligature during the course of the operation account for the immediate postoperative bleeding. The error so frequently committed is in not appreciating the signs of intraperitoneal bleeding and the delay contributes to the mortality. Usually, within the first six hours postoperative, evidence of hemorrhage is usually present but may vary with the size of the vessel involved. Once the diagnosis is established, immediate exploratory laparotomy with ligation of the uterine or ovarian vessels, or if a broad ligament hematoma obliterates the anatomical landmarks, the visualization of the internal iliac arteries followed by ligation is usually the best method for control of the bleeding. Late postoperative bleeding (10-28 days) may be controlled either by vaginal packing or vessel ligation.

The other postoperative complications are the rare protrusion of the fimbriated end of tube or the even rarer occurrence of herniation of a loop of bowel through the dehiscence of the vaginal vault.

The failures encountered in post va-

ginal surgery are late occurrence or recurrence of cystocele, rectocele, and vaginal vault hernias. The most common and most distressing is the persistence, occurrence or recurrence of stress urinary incontinence. These latter failures develop even in the hands of the most skilled and experienced gynecologists. The incidence of these failures is conservatively about 15%.

We feel that adequate mobilization and narrowing of the urethrovesical junction with proper fascial support for the urethrovesical junction and reconstruction of the urogenital diaphragm usually corrects the stress incontinence. When failures occur because of poor tissue or inadequate repair, repeated vaginal plastic may be considered, although more often the abdominal approach is utilized. The Marshall-Marchetti, the Lapidus or the Sling (Studdiford-Aldridge or Millin) procedures come into play. Occasionally, the combinations of these operations may be executed as illustrated in the following instance:

Patient—P.B.—49-year-old white female came to Cook County Hospital because of vaginal bleeding. Ten years ago, she had a Wertheim hysterectomy for carcinoma of the cervix. Examination found a lesion in the vault of the vagina which proved to be squamous cell carcinoma on biopsy. A vaginal total colectomy was performed. Her recovery was uneventful, but she had difficulty in urinating. In the urological department, a transurethral resection of the internal sphincter was performed. Following this operation, she became totally incontinent. A retention catheter was used for control. Two months later, a Lapidus and Millin Sling operations were performed with a successful result in that almost complete control of her urine was achieved. Only under severe stress or coughing (chronic smoker) she had some incontinence.

If the anatomical result appears normal while the function is not, then a careful neurologic and urologic study must be repeated. In the absence of any neurologic or urologic abnormality, the suprapubic approach is usually followed, and the Marshall-Marchetti, the Lapidus or the Sling operations of Studdiford-Aldridge, or Millin are considered. The Ingelmann-Sundburg or the Berkow have not received general acceptance. Fistula following vaginal surgery was uncommon. There was only

one vesicovaginal and one ureterovaginal fistula. The vesicovaginal fistula was repaired successfully three months after the vaginal hysterectomy and left salpingo-oophorectomy. The ureterovaginal fistula healed spontaneously after inserting a ureteral catheter for five days. Apparently this fistula was due to a partial injury to the wall of the ureter.

The rare complication during vaginal hysterectomy is finding the fundus of the corpus fixed to the anterior abdominal wall or surrounded with adhesions. This problem may be solved by allowing a thin shell of the corpus to remain while the myometrium, the endometrial cavity, and the cervix is removed; the walls of the shell of myometrium may be approximated by interrupted sutures. The procedure is practically extraperitoneal. In one instance the fundus which was fixed to the abdominal wall slipped upward and could not be reached. Since there was no bleeding, nothing further was done. However, about 18 months later the mass in the laparotomy scar had to be removed because of pain. Endometriosis was found in the fundus.

Summary and Conclusion

1. Further experiences with the the results of vaginal surgery continue to support the current concepts of vaginal surgery; that it is safe as documented by mortality and morbidity statistics.

2. The vaginal route lends itself to all forms of pelvic surgery with proper exposure; adequate accessibility to all forms of pathology can be achieved.

3. The postoperative comfort and shorter hospital stay are important factors recommending vaginal surgery.

4. Direct visualization of pelvic structures by exploratory posterior colpotomy is superior to observation through an instrument.

5. In view of the advantages of the vaginal approach, procedures may be extended particularly in obese individuals with borderline medical complications which render them poor operative risks if approached abdominally. ◀

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Approaches to Prevention of Disease

I firmly believe that in the long run human health, happiness, and useful longevity will be achieved at far less expense and with less suffering through primary prevention than through methods which seek to prolong the life of the ill. The ounce of prevention is figurative, for the cost of disability and death can be shown to far exceed a 16 to 1 ratio. We can never catch up with the problem until we begin to make inroads into the basic load of disease itself. Nor is the specter of a human population walking about with artificial hearts, kidneys, lungs, digestive tracts, and reproductive organs, and even computerized brain units, so wondrous to behold. The moral issues of these procedures may be far more profound than the addition of fluorides to a water supply which we all will drink. (Leonard M. Schuman, M.D.: "Approaches to Primary Prevention of Disease." *Public Health Reports* 85:1 [Jan.] 1970.)

A Diphtheria Outbreak in Chicago

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Diphtheria has been an increasingly uncommon disease in Illinois, but when two fatal cases of diphtheria occurred in Chicago the local medical community and Chicago Board of Health were alerted to the possibility of further cases. In the two-month period from December, 1969, to February, 1970, a total of 21 cases was diagnosed. This unexpected occurrence is described here, and its potential complications are discussed with reference to certain clinical aspects of the disease and to diphtheria in other areas of the United States.

The Outbreak

Between December 15, 1969, and February 15, 1970, a total of 21 cases of diphtheria was diagnosed in 12 unrelated groups of people in Chicago. The outbreak peaked in the second week of January, when seven cases occurred. Two of these patients died.

Clinical Features

The following general definitions were used to classify the clinical severity of the patients' illnesses.



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- Mild—focal disease, no systemic effects
- Moderate—focal disease, mild systemic effect (e.g. fever)
- Severe—focal disease, marked systemic effects (e.g. respiratory distress, shock, marked or massive cervical swelling)

Eleven of the 21 patients had mild illness at the time of diagnosis; six patients had moderate disease; and the other four (including the two who died) were classified as severe. Myocarditis was noted at autopsy in both fatal cases.

The patients with mild diphtheria most often gave a history of sore throat, and occasionally mild dysphagia of one or two days duration. Several described the nature of their sore throat as "burning." Some of these patients might have not consulted a physician if diphtheria had not been diagnosed in another family member.

The usual clinical course of the patients with moderate and severe illness was one to four days of progressive symptoms with development of sore throat, chills and dysphagia. At the time of diagnosis these patients appeared sicker than patients with similar appearing membranous pharyngitis due to different etiologic agents. This apparent toxicity often appeared out of proportion to the patient's temperature elevation; fever, if present, was usually low grade.

Two patients had only nasal involvement and presented with a serosanguineous exudate obscuring the underlying membrane. One patient had a laryngeal membrane seen at bronchoscopy, but a culture of the membrane was negative. Both patients who died had respiratory distress necessitating tracheostomy and both presumably had laryngeal involvement.

Most of the other patients had pharyngeal membranes or exudates which ranged in color from white to dirty yellow, as illustrated in the accompanying color plates (Fig. 2). The membrane was usually tonsillar, but in some patients it extended to uvula, soft palate or posterior pharynx. Edema of the uvula was often present, but there was little erythema of uninvolved mucosa, and no palatal petechiae were seen. Only one of the diphtheria patients had the suggestive oral fetor, which has been described as diphtheritic or "mousy" in nature. One other patient with a similar oral fetor was subsequently found to have infectious mononucleosis.

It should be stressed that infectious mononucleosis with a pharyngeal membrane can be differentiated from diphtheria with certainty only by laboratory tests. Four patients who were suspected of having diphtheria presented with pharyngeal membranes associated with toxicity and tender enlarged cervical nodes. As a group, these patients appeared to have higher temperatures and more prolonged courses than the diphtheria patients. The "mono slide test" was positive in all four cases upon admission, and subsequently all had positive heterophile agglutinations (Paul-Bunnell) and differential tests (Davidsohn-Lee) confirming the diagnosis of infectious mononucleosis. Because of striking initial clinical similarities between mononucleosis and diphtheria, two of these patients were treated with diphtheria antitoxin.

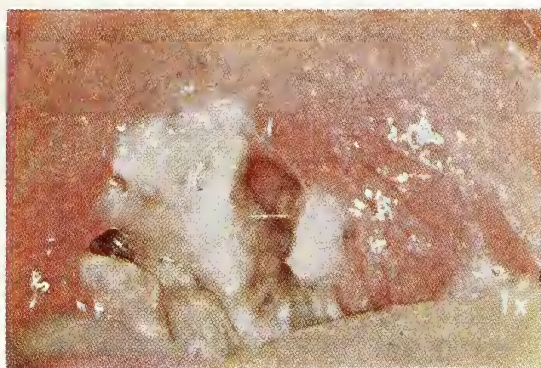
Beta-hemolytic streptococcal infections were found frequently in the diphtheria patients and seemed to be associated with a more severe initial picture. Beta-hemolytic streptococci can hinder bacteriological confirmation of *Corynebacterium diphtheriae*, which may have occurred in the initial fatal case.

Prior to treatment with equine diphtheria antitoxin (DAT) the patients had skin tests with a 1:1,000 dilution of DAT, using standard intradermal technique; none had positive tests. Treatment dosage was 40,000 to 80,000 units or more, without regard to the size of the patient. Patients with mild disease received antitoxin intramuscularly, and those with moderate or severe disease were given intravenous and intramuscular therapy. No untoward immediate reactions were observed, but in two patients mild urticarial reactions developed later, which were easily controlled with antihistamines.

After DAT therapy most patients experienced rapid improvement in clinical condition. All were re-evaluated 6 to 12 hours after treatment, and were given additional DAT if desired clinical effects had not yet been achieved. These consisted of marked decrease in toxicity and rapid disappearance of membrane.

No antibiotics were given until three cultures had been taken. Antibiotics given before admission had no apparent effect on the clinical course, but they made culture confirmation of diphtheria more difficult. Erythromycin was used for the treatment

Fig. 1. The common clinical appearance of the diphtheritic pseudo-membrane is noted. The membrane has spread from the tonsils to the uvula and palate.



1

Fig. 2. The clinical appearance of the diphtheritic pseudo-membrane is also noted here.



2



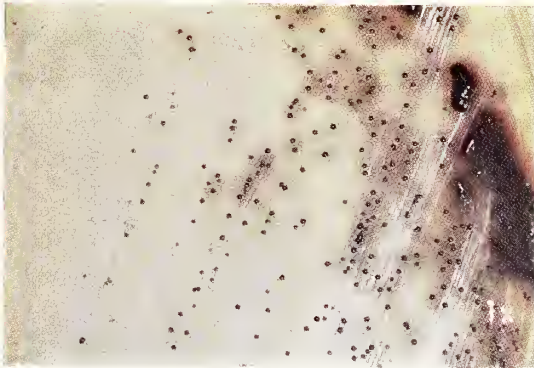
3



4



5



6

Fig. 3. The clinical appearance is very similar if not identical to that of Fig. 2, but is infectious mononucleosis and not diphtheria. These diseases cannot be easily differentiated except by appropriate serological tests.

Fig. 4. Reveals diphtheria after 36 hours of therapy with antitoxin. Note the erosion of the membrane from the tonsils which appeared previously as in Fig. 2. Also there is obviously membrane which appears to progress up the posterior aspect of the palate.

Fig. 5. Reveals the serosanguinous exudate of nasal diphtheria with a suggestion of underlying membrane.

Fig. 6. Shows the appearance of *C. Diphtheriae* on Tinsdale's medium. Such black colonies with a surrounding brownish halo are almost certainly *C. Diphtheriae*, but must be further distinguished by biological and morphological characteristics.

Table 1
Diphtheria Patients by Immunization Status and
Clinical Severity
Chicago, December, 1969-February, 1970

Number of Prior Diphtheria Toxoid Immunizations	Clinically Severity at Time of Diagnosis			Total Number of Patients
	Mild	Moderate	Severe	
None*	2	3	4	9
One	2	0	0	2
Vaccinated, number doses unknown	3	0	0	3
Three or More	4	3	0	7
Total	11	6	4	21

*7 definite, 2 probable

of cases and carriers; this antibiotic may be more effective than penicillin.^{1,2}

Seven of the diphtheria patients had definitely never been immunized with diphtheria toxoid, and two had probably never been immunized (Table 1). Two had received one dose of toxoid, and three others, an unknown number of toxoid immunizations; seven patients gave histories of three or more doses prior to onset of illness. Those patients with prior immunizations tended to have mild or moderate illnesses, and severe disease occurred only in unimmunized patients. It is important to carefully document immunization histories. This is often very difficult, but clinical decisions on antitoxin treatment may hinge on such documentations.

Shick tests were performed on nine patients; three were positive and six negative. All three with positive Shick tests gave histories of prior immunization with three or more doses of toxoid. One unimmunized patient had a negative test, but the other six with negative tests had all received some immunizations. Although a Shick test is considered a good measure of diphtheria immunity, a positive or negative result does not always correlate well with the measured antitoxin titer,^{3,4} and consequently may not correlate well with the number of previous diphtheria toxoid immunizations.

Clinical and Postmortem Findings in a Patient with Hemorrhagic Diphtheria

One of the patients who died also had an unusual hemorrhagic complication of diphtheria. This 4½-year-old boy became ill four days prior to admission with low grade fever, sore throat, anorexia and swelling of the neck. The morning of admission he began to spit up blood and experience respiratory difficulty. A diphtheria membrane, bull neck, and oral fetor were noted

on admission. Prolonged apnea and hypoxia occurred, and he was intubated. The subsequent hospital course was characterized by decerebrate posturing, diphtheritic nephritis, petechial hemorrhages, and bleeding from the nasopharynx and needle puncture sites. The patient was treated with penicillin, diphtheria antitoxin, intravenous heparin and blood transfusions. However, myocarditis developed; major conduction abnormalities were noted on electrocardiogram. He died on the third hospital day of shock due to cardiac failure.

A culture of the membrane was positive for toxigenic *C. diphtheriae*, intermedius type. Initial hematologic studies showed a hematocrit of 30% and a white blood cell count of 28,600 with 49% polymorphonuclear cells, 15% band cells, 1% basophils, 20% lymphocytes, and 1% monocytes. The platelet count was 21,000, clotting time 9 minutes, and no clot retraction was demonstrated after 1 hour observation. The prothrombin time was 14.7 seconds with a control of 13 seconds, and a partial thromboplastin time was 48.8 seconds. Urinalysis on the first hospital day showed 3 plus to 4 plus protein and no red blood cells; it was otherwise normal, but 4 plus occult blood and moderate red blood cells were present in a second urine sample. A chest X-ray showed pneumonitis.

At autopsy, nasopharyngeal and tracheal diphtheria was found and bacilli resembling *C. diphtheriae* were present in the tracheal exudate. Petechial hemorrhages were scattered throughout the viscera, pleural surfaces, and thyroid. The brain was edematous with flattened gyri, and a pressure cone was noted. The lungs had interstitial and intra-alveolar hemorrhages. The bronchioles were filled with fibrinous exudate, and the tracheal membrane was composed of a fibrinous material and polymorphonuclear cells. Microscopic examination of the heart showed focal hemorrhages and interstitial edema. Kidney examination revealed marked swelling and degeneration of the tubular epithelium, and focal capillary or calycal hemorrhages were present bilaterally, but no fibrin thrombi were found in the kidney or elsewhere. There was extensive necrosis of the adrenal cortex with moderate congestion. Decreased erythroid elements and megakaryocytes were noted in bone marrow.

Hemorrhagic diphtheria as exemplified

in the case reported here is seen only rarely in diphtheria. It occurs in 1-6% of diphtheria patients, with the highest incidence noted in patients whose diphtheria was due to *intermedius* type *C. diphtheriae*.⁵

The clinical course in this patient was similar to that noted in other patients with hemorrhagic diphtheria;⁶ severe diphtheria with petechial hemorrhages and bleeding from the nasopharynx and needle puncture sites. Marked thrombocytopenia appears to be a constant feature, but a compensatory thrombocytosis occurred in the only patient to survive.⁷

Hemorrhagic diphtheria is almost always fatal, with 70 deaths in 70 cases in one series,⁶ and 12 deaths in 13 cases in another series.⁷ Cytopathic changes in megakaryocytes were reported, and this was proposed as a possible explanation for the thrombocytopenia and hemorrhages. Intravascular coagulation with small vessel fibrin deposition was considered as an etiologic mechanism causing the bleeding in this case. Apparently heparin was administered because of this consideration. However, fibrin deposits in blood vessels were not seen in the autopsy. Marked fibrin deposition was noted throughout the trachea, larynx and bronchioles. Additionally, diphtheria toxin may cause localized endothelial damage, which could result in the hemorrhagic complications.

Table 2
Diphtheria Patients by Age Group
Chicago, December 1969-February 1970

Age Group	Number of Patients
0-4	6
5-9	4
10-14	8
15+	3
Total	21

Epidemiology and Control Measures

The patients ranged in age from 11½ years to 60 years although the majority (86%) were 14 or under (Table 2). Ten of the patients were girls; 19 were Caucasians, including 11 of Puerto Rican extraction; and two were Negroes.

Twelve households or extended family groups were involved, all located within low-income, high-population-density areas around the center of the city. Although most resided in neighborhoods which experience a high degree of population turnover due to in-and-out-migration, many of the patients had resided in Chicago

from birth. The "diphtheria households" were located one-half to 13 miles apart, with the majority of cases in the near northwest region of the city.

The children in each of these groups attended different schools, and none of the groups had any known contact with the others through social, recreational, work experience, travel, holiday season activity or child care services. None of these people had visited other areas of the country known to have diphtheria nor did they have visitors from such areas.

On January 3, and 8, a "Task Force Committee" composed of Chicago Board of Health personnel and consultant university physicians planned control measures. These included distributing culture media to hospital emergency rooms throughout Chicago to evaluate suspect cases and setting up a program for centralized bacteriologic examination of the cultures. Persons with cultures positive for *C. diphtheriae* or with clinically suspect illness were hospitalized for treatment. Special well publicized immunization clinics were set up near the diphtheria households, and immunization teams were sent to the schools of the diphtheria patients. By February 14, more than 201,000 doses of diphtheria toxoid had been given by Board of Health personnel at the special immunization clinics.

Case contact investigations resulted in the identification of seven bacteriologically confirmed carriers of *C. diphtheriae* among 73 immediate household contacts (10%) who were cultured. One carrier was identified among 33 other close contacts (3%) who were cultured.

All carriers were hospitalized or confined to home for seven to ten days and treated with erythromycin. They resumed their previous activities after three negative post-treatment cultures. All case contacts were immunized with diphtheria toxoid.

Bacteriology

Nineteen of the 21 patients had cultures positive for *C. diphtheriae*. One patient with a negative culture died of clinical diphtheria with myocarditis, two of her siblings also had clinical diphtheria with positive cultures, and a third sibling was an asymptomatic carrier of *C. diphtheriae*. The other patient with a negative culture had a laryngeal membrane which appeared characteristic of diphtheria.

Nine of the patients, from six of the 12 household groups, had intermedius type *C. diphtheriae*. Three other patients directly associated with these patients probably had this type of *C. diphtheriae* also. All the intermedius strains were toxigenic.

Mitis type *C. diphtheriae* was cultured from three patients, each from a different household. Two of these isolates were nontoxigenic and one was toxigenic. Both patients infected with nontoxigenic strains had mild illnesses.

Cultures were taken from the anterior and posterior nares utilizing cotton-tipped nasopharyngeal wires, and from the oropharynx and tonsils using standard sterile cotton swabs. Loeffler's medium was inoculated, and after incubation for 12-24 hours, methylene blue stained smears of the cultures were examined for suspicious organisms. When suggestive morphology was present, the organisms were transferred to modified Tinsdale's medium. If the organisms were *C. diphtheria* in 2-5 days incubation, the typical dark brown to black colonies with the surrounding brownish-black halo were observed. Correct interpretation of morphology of diphtheria and diphtheroids from Loeffler's medium may often be a difficult problem. Consequently a second method was utilized: swabs from the nasopharynx were incubated with heart infusion broth for 2-4 hours and then streaked on modified Tinsdale's medium. The characteristic colonies were picked from the agar surface for further study. Such colonies are almost invariably *C. diphtheriae* or other corynebacteria or *Staphylococcus aureus*.⁸ The staphylococci can be separated by microscopic morphology, and the other corynebacteria by differential biochemical tests. Also, it should be noted that sometimes Tinsdale's medium inhibits growth of *C. diphtheriae*, and each batch should be checked with control cultures before being used for diagnostic purposes.

Toxigenicity tests were performed using the Elek plate technique.^{8,9} Difficulties due to multiple precipitate lines were avoided by incorporating recently suggested modifications into the technique.¹⁰ Toxigenicity tests in guinea pigs were used as controls.^{8,11}

Discussion

Diphtheria incidence has been decreasing since before 1920, and it appeared to

be disappearing. However, recent outbreaks recorded in Austin, Texas,² Phoenix, Arizona,¹² Miami, Florida,¹³ and now Chicago indicate that the disease is still an important clinical and public health problem.

Certain features were common in the Chicago outbreak and the other recent urban outbreaks. Scattered cases occurred in inadequately immunized poor people who lived in crowded conditions. That such conditions undoubtedly exist in other places in Illinois, indeed throughout the United States, suggests diphtheria may continue as a recurring problem in inner-city and lower socioeconomic groups.

Although 20-30% of untreated diphtheria patients die,^{14,15} early diagnosis and treatment can lower the case fatality ratio to about 5%.^{2,16} Additionally, the prognosis is dependent on a number of other factors.¹⁷ The case fatality ratio is higher for infants and old people, and those with underlying medical conditions. Primary cutaneous, nasal, or laryngeal diphtheria is associated with low death rates,^{14,18} and extensive involvement, bull neck, and hemorrhagic diphtheria have high case fatality ratios.

Prior immunization with three or more doses of diphtheria toxoid is generally associated with mild disease, but severe diphtheria and death can occur in supposedly fully immunized individuals.^{19,20,21} Persons with up-to-date immunizations against diphtheria have been shown to harbor and become infected with *C. diphtheriae*.² As such, these individuals could transmit the organism to unimmunized persons who could develop severe disease leading to death. Physicians should consider a diagnosis of diphtheria for any child or adult with a suggestive clinical illness, in spite of the immunization history.

Diphtheria is a clinical diagnosis, and one cannot wait for laboratory confirmation before initiating effective treatment. The death rate almost doubles with each day antitoxin treatment is delayed, and if therapy is delayed beyond the sixth day of disease there may be no improvement in the death rate.¹⁴ Additionally, there is a marked increase in toxin associated complications with each day of delay. Antitoxin treatment at the time of clinical diagnosis implies that some patients who ultimately are proven to have other diseases

will be treated with antitoxin; the risk from such treatment is less than the risk from failure to treat diphtheria.

Antibiotic therapy before adequate cultures have been taken may prevent bacteriologic confirmation and may not interrupt the cycle of bacterial growth, toxin production and membrane formation.^{14,15} Erythromycin is probably the best antibiotic for eradicating *C. diphtheriae* from persons with positive cultures, a 10% failure rate has been reported with penicillin.² Prior to definitive culture results, treatment of asymptomatic family or case contacts with antibiotics is not recommended, because such treatment may mask the features of diphtheria, make the diagnosis difficult, and not necessarily prevent the development of late complications, such as neuritis and myocarditis.

Toxicogenicity correlates well with disease, but some nontoxicogenic strains have caused severe disease and death.^{15,22,23} A nontoxicogenic isolate should not be viewed as an "avirulent" or nonpathogenic organism.²⁴

Summary

In Chicago diphtheria was thought to be a sporadic disease, affecting only a few unimmunized persons each year, who had lived or traveled in the Southern U.S. The sudden occurrence of 21 cases in a two-month period suggests that the disease may be more widespread than is generally thought.

The fact that the first two cases diagnosed were severe and fatal and the next 19 moderate or mild, with no fatalities, suggests that early in the outbreak only the severe cases were recognized as diphtheria and milder antecedent cases may have existed but were not diagnosed. It is also possible that *C. diphtheriae* is endemic in the inner-city community, where immunization levels are low. Consequently, diphtheria may be a continuing health problem.

In areas where the people have low immunization levels and live in crowded conditions, diphtheria outbreaks may occur and continue. It has been estimated that in densely populated urban areas, where *C. diphtheriae* is endemic, at least 70%,²⁵ or perhaps more than 90%² of preschool and school age children must be immunized to prevent diphtheria. Routine diphtheria toxoid immunization at recommend-

ed intervals²⁶ is the best measure to prevent future diphtheria outbreaks.

The value of centralized laboratory and treatment facilities for infectious diseases represented by Municipal Contagious Disease Hospital and the Chicago Board of Health was demonstrated in this outbreak.

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Meeting Memos

Every Monday—Chest Conference

10:00 a.m. Edgewater Hospital
5700 North Ashland Avenue, Chicago

Every Thursday—Combined Cardiology Conference

11:00 a.m. Edgewater Hospital
5700 North Ashland Avenue, Chicago

May 16—The Chicago Gynecological Society

Seminar on Obstetrics and Gynecology
Drake Hotel, Chicago

May 17-20—Illinois State Medical Society

Annual Meeting
Sherman House, Chicago

May 22-29—International Union Against Cancer

Tenth International Cancer Congress
Houston, Texas

June 9-11—University of Missouri

Postgraduate Course
"Lesions Related to the Spinal Cord"
University of Missouri, Columbia, Mo.

June 8-July 3—Oak Ridge Associated Universities

Course
Radioisotopes in Research
Oak Ridge Associated Universities, Oak Ridge, Tenn.

June 11-13—Wisconsin Heart Association

Annual Meeting and Scientific Session
University of Wisconsin, Madison

June 14—Chicago Society of Allergy

Fortieth Anniversary Social Meeting
6:30 p.m. Armando's Restaurant, Chicago

June 16-19—American Association of Medical Society Executives

Seminars
Lake Geneva, Wis.

June 19-20—Cook County Graduate School of Medicine

Seminar
"Management of Burns"
Tuition \$70
Cook County Hospital

June 20—American Association of Medical Society Executives

Annual Meeting
Chicago

June 20—American Association for the Study of Headache

Annual Meeting
Continental Plaza Hotel, Chicago

June 21-25—American Medical Association

Annual Meeting
Palmer House, Chicago

June 23-24—American Medical Society on Alcoholism

Annual Meeting
American Hospital Association Bldg., Chicago



IMJ

**SURGICAL
GRAND
ROUNDS**

Pelvic Trauma

Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m., alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Chicago Wesley Memorial Hospital on August 2, 1969.

EDITED BY JOHN M. BEAL, M.D.

Case Report:

Dr. Earl Wendel: A 48-year-old white male, crane operator was in good health until 2:30 p.m. on June 30. At this time he was helping repair the boom of a fork lift. While he was lying on the ground working, the boom of the fork lift, which weighs approximately 1000 pounds and is 7 feet tall, broke from its moorings and fell on the patient. It struck him across his left loin, pubis and right thigh. He did not lose consciousness but "felt as if everything in his pelvis was crushed," and suffered pain in his rectum and in his perineum. He was brought to the emergency room of Chicago Wesley Memorial Hospital where an intravenous infusion was started, a Foley catheter was inserted by the surgical resident because of bleeding from the urethra, and a nasogastric tube was inserted. The patient was alert and well oriented. His blood pressure was 125/65, his pulse 100/min., respirations 28/min., lungs clear, and examination of the heart normal. The upper abdomen was

very slightly distended, and a few bowel sounds were present. The lower abdomen was distended to the level of the umbilicus and there was discoloration of the penis. There was a typical "derby hat" tense blue scrotum and very slight bulging in the peritoneum. Rectal examination revealed the bag of the Foley catheter in the perineum. There was a very definite notching of the urethra distal to the prostatic apex which was felt to be diagnostic of a urethral rupture. There was numbness of the entire right leg from the thigh downward; however, he was able to move both lower extremities, although his right leg was weaker than his left. Deep tendon reflexes were intact and pathological reflexes were not present. White blood count was 14,100, with 72 polymorphonuclear leukocytes; hematocrite was 45%, and hemoglobin was 15 gm%. X-rays were taken.

Dr. Earl J. Nudelman: A plain film of the abdomen was taken in the emergency room. There were fractures of the superior and inferior rami of the pubis on the

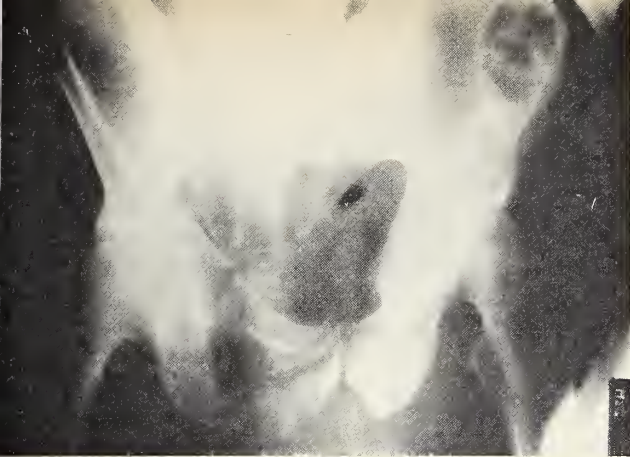


Fig. 1. Oblique view of pelvis demonstrates fractures of superior and inferior rami of right pubic bone.

right, and another fracture of the pubis on the left, with little displacement (Fig. 1). A second film was taken after insertion of a catheter. Contrast material was injected through the catheter and was seen to extravasate about the base of the bladder. (Fig. 2). Some of the contrast material entered the bladder which was found to be displaced. The separation of the bladder from the pelvis indicated the presence of a large hematoma. The radiologic study demonstrated rupture of the posterior urethra, fractures of the pelvis, and a large hematoma about the base of the bladder.

Dr. Wendel: The Urology Service now undertook management of the patient, and a second intravenous infusion was started with a central venous pressure catheter, and the first of two units of whole blood was begun. The patient was moved to the operating room. Following the induction of general anesthesia, a vertical suprapubic incision was made, and the anterior perivesical space was opened. A large amount of blood, mixed with clots and urine, was evacuated. The estimated blood loss was 1500 cc. The bladder was found to be ruptured anteriorly with the tear extending from the dome to the bladder neck and including a portion of the prostate itself. The prostate was depressed slightly toward the rectum and the distal portion of the urethra, which was completely severed in the membranous portion, was displaced anteriorly. The ends of the severed urethra were approximated by use of interlocking sounds and a catheter was threaded through the urethra into the bladder. The bladder was subsequently closed around a suprapubic Pezzar catheter. Three Penrose

drains were placed in the perivesical space. The bladder wall was markedly thickened by hemorrhage into the wall. A small incision was made in the peritoneum and it was determined that free blood was not present in the abdominal cavity. The peritoneum was then closed.

Postoperatively, the patient did reasonably well. He drained a moderate volume of urine and blood through the perivesical drains for several days, but subsequently this closed spontaneously. The patient now is draining urine through his Foley catheter and suprapubic tube. Drain sites are dry, and his wound is well healed. His pelvic fracture was treated initially with immobilization and subsequently with pelvic sling. The patient is walking four weeks after injury.

Dr. George J. Bulkley: At the time of operation, the bladder was torn to a greater extent than had been anticipated from reviewing the X-rays. The X-ray is typical of the "hour glass" bladder which often is seen with a pelvic hematoma compressing the lateral walls of the bladder. We were surprised to see the extent of the rupture of the bladder which had occurred.

In attempting to repair the prostatic urethra, we first tried to pass a Foley catheter from below under direct vision, but found that the catheter went out the torn urethra into the perineal tissues. Therefore, we used a maneuver which is often helpful—interlocking metal Van-Buren sounds. One was passed through



Fig. 2. Injection of contrast material through catheter extravasated in tissues about base of bladder. The bladder is elevated and displaced by pelvic hematoma.

the urethra to the point of rupture, and the other from the bladder until the tips joined together. Then the urethral sound was advanced into the bladder. This sound has a small hole in the tip which enabled us to put a silk suture through it. The silk is then pulled out through the urethra and tied onto a Foley catheter which then can be brought back into the bladder, thus establishing the continuity of the urethra. Direct exposure of the cut ends of the urethra is not necessary and would be very difficult. If the freshly traumatized ends are splinted by a Foley catheter, they will heal. We plan to leave this catheter in place as a splint for approximately six weeks and the suprapubic catheter for seven weeks to provide adequate urinary drainage until he begins to void satisfactorily. In spite of these catheters, much of the urine drains out around them or through the Penrose drains for the first week or ten days. These three large Penrose drains were inserted down to the site of injury to prevent stasis of extravasated urine. The danger of extravasation of urine is not in the fluid itself, but in potential pocketing of inadequate drainage which leads to infection and sepsis. We have found large Penrose drains superior to hemovac or other suction tubes, because they allow escape of blood and seldom become obstructed or clogged.

I think that a review of the management of injury to the lower urinary tract would be helpful. Approximately 10% of pelvic fractures will be complicated by rupture of the urethra or of the bladder. In the present case, the diagnosis was readily suspected because the trauma was severe; but in many cases of pelvic fracture, it is not this easy to make the diagnosis of urethral or bladder injury.

Following are some important things to remember. When the bladder ruptures, it ruptures extraperitoneally in 80% of the patients. Blunt trauma, such as occurred in this case, will rupture a full viscus; but an empty bladder seldom ruptures unless there is fracture of the protective bony ring of the pelvis which surrounds it. This was certainly true of this case. The membranous urethra is the only fixed point from the bladder to the tip of the penis, and this is very often the site of the rupture or tearing when there is a fracture of the pelvis.

Review of pelvic anatomy, particularly of fascial planes, will give the basis for the clinical findings in such cases. The spread of extravasated urine and blood is limited by the fascial planes, particularly Colles' fascia in the scrotum, Buck's fascia around the penis, Scarpa's fascia on the abdomen, and the urogenital diaphragm. Rupture below the urogenital diaphragm allows spread into the scrotum, perineum, and rarely into the penis itself. The swollen bluish scrotum produces a "derby hat" appearance described by Dr. Wendel in our present patient. Rupture above the urogenital diaphragm in the prostatic urethra or bladder allows spread into perivesical spaces and onto the abdominal wall. This also occurred in the patient presented today.

When the bladder is ruptured intraperitoneally, there is, of course, extravasation into the peritoneal cavity. This did not occur in the patient discussed today, and was excluded by the X-ray findings as well as the exploratory opening of the peritoneal cavity at the time of operation.

The value of rectal examination needs emphasis. When there is injury and rupture of the urethra, one usually feels a boggy mass. The prostate is elevated and pushed away by the hematoma.

The key to the diagnosis in the patient today, on the initial physical examination, was the distended lower abdomen, the extravasation of blood into the scrotum and perineum and the elevated prostate on rectal examination. In less severe injury, the patient is able to void. If he voids clear urine, rupture of the urethra is unlikely, although still possible. If the patient is unable to void, an attempt is made to pass a catheter. If the catheter will pass, X-rays are taken with injection of dye through the catheter to demonstrate the integrity of the bladder or urethra. If the catheter will not pass, we inject dye directly into the tip of the penis to demonstrate the rupture of the urethra. In some instances of pelvic fracture, the patient may be unable to void, and when the X-rays are obtained with injection of contrast agent through the catheter, an hour-glass deformity of the bladder may be seen. However, if the urethra and bladder are intact, operation is not indicated (Table I).

Table I.

Plan of Action

1. Patient voids
 - a. Clear urine—observe
 - b. Bloody urine—catheterize
2. Catheter passes
 - a. Leave in place and do cystogram
 - b. Operation if rupture is demonstrated
3. Catheter will not pass
 - a. Do urethrogram
 - b. Operation will be necessary

The principles of treatment are really fairly obvious, and one may proceed with treatment in an orderly manner. We first control obvious bleeding, then drain extravasation of urine and attempt closure of the deep tears if possible. One does not have to visualize the exact extent of the urethral rupture. Bladder rupture is closed under direct vision carefully, but the urethra requires only approximation. When the catheter is passed into the bladder, slight traction can be applied, which pulls the prostatic urethra down to the disrupted end, and the urethra will heal (Tables II, III, and IV).

Table II.

Ruptured Bladder

1. Cystotomy—suprapubic incision and bladder opened.
2. Repair visualized tears in wall.
3. Examine peritoneal cavity to evacuate blood and urine. Close peritoneum without drainage.
4. Drain perivesical areas to allow escape of blood and urine.
5. Drain bladder with suprapubic tube.

It may be pointed out that the urologist's favorite instrument, the cystoscope, is not used in this situation. There is no point in trying to visualize this injury with a cystoscope. Examination of the patient and X-rays of the urethra and bladder will delineate the extent of injury.

Table III.

Ruptured Urethra

1. Cystotomy—suprapubic incision and bladder opened.
2. Retrograde catheter or interlocking sound passed from above through urethral tear and catheter guided into bladder and left indwelling. Traction applied to Foley catheter when the prostate is separated from the membranous urethra.
3. Drainage of extravasated blood and urine from the perineum, scrotum, and penis. Control of perineal bleeding sometimes required.
4. Re-approximation of torn urethra under direct vision seldom required.
5. Urethral catheter left in place as splint.
6. Suprapubic tube also left in place to divert urine while urethra heals.

"There is no grievance that is a fit object of redress by mob law."—Abraham Lincoln.

Table IV.

Contusion of Bladder or Urethra Without Rupture

1. Minor contusion of the bladder requires only observation.
2. More severe contusion without rupture requires catheter drainage for short period.
3. Urethral contusion with hematoma or partial tear requires a splinting indwelling catheter.

Dr. Beal: Dr. Meyer, have you any comments about management of this pelvic fracture and of pelvic fractures in association with bladder injury?

Dr. Paul Meyer: Early catheterization is useful in patients with pelvic fracture. Many are unable to void because of pain, even though there is absence of urinary tract injury. In addition, we want to check their output. More important, the extent of pelvic hematoma can be detected best by cystogram. A pelvic hematoma can form rapidly after pelvic fracture and may represent a large volume of blood loss. 1500 to 2000 cc of blood is frequently extravasated in pelvic fracture. The obturator artery, a branch of the hypogastric, is usually the one that does the bleeding and on occasion has required surgical intervention and ligation. The patient that was presented today will be immobilized for four weeks. When there is marked displacement of the fragments or joint involvement, immobilization is extended to six or eight weeks.

Dr. James K. Stack: We have seen pelvic fractures caused by a man being caught between the side of a boxcar and a loading platform. We should be careful about the ultimate prognosis, because the circulation to the femoral head can be damaged even though the fracture itself may be in the acetabulum and not in the capital epiphysis.

Dr. Stuart M. Poticha: This is one of the most common types of abdominal injury which was seen when I was in Vietnam because of land mines. A soldier steps on a land mine, and the fragments come up from the ground and into the perineum, fracture the pelvis, producing a serious and complex problem. The rectum is frequently involved. The treatment is essentially as outlined by Dr. Bulkley, with the addition of a colostomy. When the rectum is involved, the problem is much worse, because the hematoma gets infected even when a colostomy is formed. Many develop an osteomyelitis of the pelvis. ◀

Therapy for

AHF and PTC Hemophilia

BY RUTH ANDREA SEELER, M.D./CHICAGO

Part I of a two-part article

The availability of plasma concentrates has completely changed the outlook for patients with hemophilia. In centers equipped to monitor the levels of coagulation factors, even neurosurgical and orthopedic procedures are safely undertaken. This article reviews the laboratory, clinical and therapeutic considerations necessary for optimal management of patients with AHF or PTC deficiency. No attempt will be made to discuss the multitude of other bleeding disorders.



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Hemophilia includes defective production of AHF (antihemophilic Factor, Factor VIII, Hemophilia A), PTC (plasma thromboplastin component, Factor IX, Christmas Disease, Hemophilia B), or PTA (plasma thromboplastin accelerator, Factor XI, Hemophilia C).¹⁻⁵ It is imperative that the coagulation defect be determined because the concentrates are specific for either AHF or PTC. The clinical severity depends upon the level of the deficient factor not its type. A boy with less than 1% PTC has as severe a bleeding disorder as a boy with less than 1% AHF.⁶⁻⁷ Within a given family the severity of the defect is similar. One doesn't have mild and severe hemophiliacs within the same family.

Clinical severity correlates well with the measured levels of AHF or PTC. A level of 1% or less is clinically severe presenting with the excessive bruises and spontaneous hemarthrosis. Patients with 2 to 5% have a moderate deficiency and greater than 5% a mild disorder.⁸ The mild hemophiliac frequently is not diagnosed until he is older and excessive hemorrhage follows contact sports or surgery.⁶⁻⁸

As with all of medicine the clue to disease begins with a thorough history. Both AHF and PTC are inherited in a sex linked recessive¹ manner and thus, rarely found in females.⁹⁻¹² One wants to know if any of the mother's male relatives are bleeders. Did the mother have any brothers who died of "complications" after relatively minor trauma, during or shortly after surgery, or have extensive hemorrhage after dental ex-

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Medical Progress Editor

traction? Do any males have arthritis or bad joints of the lower extremities or are they confined to wheel chairs at an early age? The same information must be sought for male offspring of the mother's sisters.

The severe hemophiliacs are usually well known to family members because of easy bruising during the first year, hemorrhage from minor mouth lacerations incurred while learning to walk, and spontaneous hemorrhage into muscle and joints.^{1,6-7} Spontaneous mutations arise, thus, hemophilia occurs with a truly negative family history.¹³ Because the females are unaffected except in extremely rare circumstances,⁹⁻¹² the gene for hemophilia may be transmitted for generations among the females without detection.

Laboratory Diagnosis

Proper screening tests for bleeding disorders are a partial thromboplastin time (PTT) and prothrombin time (PT) to detect the coagulation deficiencies. To rule out platelet disorders, a platelet count, bleeding time and clot retraction are needed. The whole blood clotting time is of little value and should be omitted; it is normal in some patients with severe hemophilia and most patients with mild and moderate hemophilia.¹⁻⁶ The PTT detects clinically significant depressions of all the coagulation factors except Factor VII and XIII. The PT is sensitive to Factor V, VII, X, II, fibrinogen. An abnormal PTT, and normal PT, bleeding time, platelet count is typical for hemophilia. Hageman defi-

ciency gives the same laboratory results as hemophilia but is usually unassociated with a bleeding disorder and can be diagnosed using appropriate studies.²⁻⁵ A number of PTC hemophiliacs have a prolonged PT. These patients are thought to have an abnormal PTC molecule in contrast to the usual absence of PTC.¹⁴⁻¹⁵ Clinically they are hemophiliacs requiring replacement therapy for bleeding episodes.

The commercial availability of plasmas deficient in AHF or PTC now make it possible for any laboratory doing a PTT to identify an AHF or PTC deficiency. When the PTT of an equal mixture of patient and identified deficient plasma is abnormal, the diagnosis is established. It should be confirmed by assay of the specific factors.¹⁶ Whenever surgery is undertaken it is not enough to know the type of hemophilia. Under such circumstances it is mandatory to follow the patient with specific assays to be sure that adequate levels for hemostasis are maintained.

Inhibitors—Anticoagulants

The severe hemophiliac without measurable levels of AHF or PTC may develop antibodies to the deficient coagulation factor after transfusions.^{1,2,3,35} The antibodies act enzymatically as an anticoagulant, very rapidly destroying all infused AHF.¹⁷⁻¹⁹ The management of patients with an anticoagulant remains a formidable problem for the most experienced hematologist.

In such situations transfusions are avoided and local measures utilized to treat the bleeding episodes. The antibody titer decreases with time but anamnestic responses are characteristic, if life-threatening situation attempts to overcome the anticoagulant and achieve measurable levels of AHF include exchange transfusion followed by infusion of very large quantities of concentrates and cryoprecipitate.^{19,30,35}

No elective procedures necessitating transfusion therapy are undertaken without checking the patient for the presence of an anticoagulant.²⁰ In fact, patients should be screened regularly to detect antibodies while they are of a low titer. The higher the titer the longer it takes to disappear and the longer the time the patient is absolutely nonresponsive to therapy.

Therapy

Plasma therapy for hemophilia has definite limitations. The infused AHF is distributed through the recipient's 50 cc per kg plasma volume, thus, the infusion of 10 cc/kg from a donor with 100% activity theoretically would give a level of 20% in the patient.

$$\frac{10 \text{ cc/kg} \times 100\%}{50 \text{ cc/kg (plasma vol.)}} = 20\%$$

When using AHF concentrates, the same dilutional relationship prevails. One unit of AHF equal to 1 cc of fresh pooled plasma with 100% activity. Thus the infusion of 1 unit/kg of AHF will give an average rise of 2% (0.02 units) in the patient.^{21,44}

Because of the relative short half life (8-12 hrs.) of AHF, repeated infusions are needed to maintain therapeutic effectiveness.^{21,22,25} The infused plasma remains within the vascular system but the AHF activity is lost, thus, subsequent infusions are diluted by a greater volume. Circulatory overload limits the usefulness of plasma to situations requiring only one to three infusions.

The first advance in therapy was Fibro-AHFR, a cold alcohol precipitation of AHF and fibrinogen.^{22,23} The fibrinogen and AHF are lyophilized and stable under refrigerated storage. Although the recommended dose of 0.1 gm/kg of body weight or 10 cc/kg is identical to plasma, 6/7 of the volume is promptly excreted by the kidneys because the protein concentration is 1 gram %. Chronic circulatory overload is thus minimized. The normal Anti A and Anti B isoagglutins are present and intensive therapy may cause a Coombs positive hemolytic anemia in the patient of blood group A, B or AB.²⁴

Hepatitis is an ever present problem and pooled donors increase the hazard. Bacteremias and meningitis with organisms of low pathogenicity have occurred in patients after intensive therapy with this product. The high fibrinogen levels resulting from the daily or more frequent infusions are thought to interfere with the normal clearance of bacteria from the circulation.

Further improved therapeutic agents followed the discovery that AHF precipitated as a cryoglobulin.²⁵ Thus, it became possible for any blood bank to prepare AHF

concentrates. Immediately after drawing, the blood is centrifuged and the plasma frozen quickly at -70°C. The frozen plasma when thawed in a refrigerator forms a precipitate which contains approximately half the AHF of the original plasma. The plasma is decanted off the cryoprecipitate, which, when refrozen and stored at -70°, is good for one year. The 7-10 ml of cryoprecipitate usually contains between 50-125 units of AHF (1 unit of AHF is the activity of 1 cc of fresh pooled normal plasma). The protein concentration is less than 1 gm%²⁵, thus, there is little potential for chronic increase in blood volume even when hundreds of bags are used.^{42,45} Variables such as a donor AHF level, rapidity of initial freezing, rapidity of refreezing and storage temperature affect the activity as does the reconstitution of the cryoprecipitate.^{25,29} For administration the bags of cryoprecipitate are thawed at 37° and 5 cc of citrate saline added to each to decrease viscosity. The needed number of bags are combined and infused as rapidly as possible after thawing. The transfusion of the cryoprecipitate from 1 unit of blood per 6-8 kg will usually result in a level of 35-40% AHF in the patient.^{26,29}

The cryoprecipitate must be filtered through a blood transfusion filter prior to administration. The easiest way to administer the material is via large (50-60 cc) plastic syringes. Glass syringes inactivate the AHF. Using a blood infusion set, we sterily cut the tubing 5-10 cm beyond the filter. The plastic syringe hub is fitted into the cut end of the tubing and the viscous cryoprecipitate pulled through the filter. The filter is then put into the next unit and the process repeated. We then administer the filtered cryoprecipitate directly by syringe. It is our policy not to leave a "keep open" intravenous running between infusions unless there are other reasons for the patient to be N.P.O. An infiltrated intravenous in a hemophiliac causes unnecessary bleeding and pain. Most patients, including children, prefer the freedom of their hands and a subsequent venipuncture to a constant intravenous infusion.

The isohemagglutins precipitate with the AHF, thus type specific cryoprecipitate is preferred. When multiple infusions are necessary for surgery an iatrogenic Coombs positive hemolytic anemia in patients of

A, B or AB blood types may be produced by using cryoprecipitate from O blood donors.²⁷⁻²⁸ Likewise, Rh negative cryoprecipitate²⁹ should be used in Rh negative patients because one cannot remove every red blood cell in the preparation of cryoprecipitate.

When cryoprecipitate preparation is combined with plasmaphoresis it is pos-

sible for a single parent or relative to stockpile large quantities. A donor can give 500 cc of plasma twice a week for a year (208 units of cryoprecipitate) without lowering the plasma proteins. An added bonus is that the chronic plasmaphoresis increases the donor's AHF level and the potency of the cryoprecipitate.

(To be continued)

The second half of this article, dealing with commercial preparations, concentrates, surgery, lacerations, fractures and prophylaxis, will appear in the June *Illinois Medical Journal*.

Physician Safeguards

Federal Bureau of Narcotics Lists 15 Don't's

The Federal Bureau of Narcotics has prepared *Don't's for the Practitioner* to protect him from narcotic addicts and abusers.

Don't leave prescription pads around; addicts may be forgers.

Don't write a narcotic prescription in lead pencil, or any Rx at all in pencil as they may be changed to call for morphine.

Don't write narcotics as "Morphine HT $\frac{1}{2}$ # X" or "Morphine HT $\frac{1}{4}$ # 10." Several X's or zeroes can be added to raise the amount. Use brackets or spelling.

Don't carry a large stock of narcotics in your bag. Addicts are often watching MD's offices and cars.

Don't store your office narcotic supply unprotected, especially near a sink or washroom; patients may ask to use these facilities.

Don't fall for a story from a stranger claiming an ailment that usually requires morphine. The addict can produce blood sputum, simulate bad coughs or other symptoms. Make your own diagnosis.

Don't give an Rx to anyone except the actual patient. Addicts have posed as nurses.

Don't write for large quantities of narcotics unless unavoidable. Diversion to addicts is profitable, as much as \$1 for $\frac{1}{4}$ grain M.S.

Don't prescribe narcotics on the story that another physician has been doing

so; consult that physician or hospital records.

Don't leave Rx's signed in blank for nurses to fill in; many have been stolen by addicts.

Don't treat an ambulatory addict. They must be under proper control; many go to several physicians at one time.

Don't dispense narcotics without keeping records, although bedside and office administration is permissible.

Don't buy your office narcotic needs on an Rx blank. The law requires that you use an official order form.

Don't resent a pharmacist's call for verification of an Rx. He is held responsible if forgeries are filled.

Don't hesitate to call an agent of the Federal Bureau of Narcotics (at your nearest Federal Building) or the Narcotics Division of your State Department of Health if the patient is suspect. Your information will be held in strict confidence.

Do not phone in a *Class A Narcotic* Rx except in true emergencies; even then, the pharmacist must have a written prescription in the Doctor's or his agent's hand before he can make delivery to your patient. The pharmacist or his agent may pick up the Rx at your office or at the home before making delivery.

Violations of this section of the narcotic law may entail two to 10 years imprisonment and up to a \$20,000 fine for the first offense; second and third violations are more severe.



THE VIEW BOX

BY LEON LOVE, M.D.

*Director, Department of Radiology, Loyola University Hospital
and Chairman, Department of Radiology, Loyola University
Stritch School of Medicine*

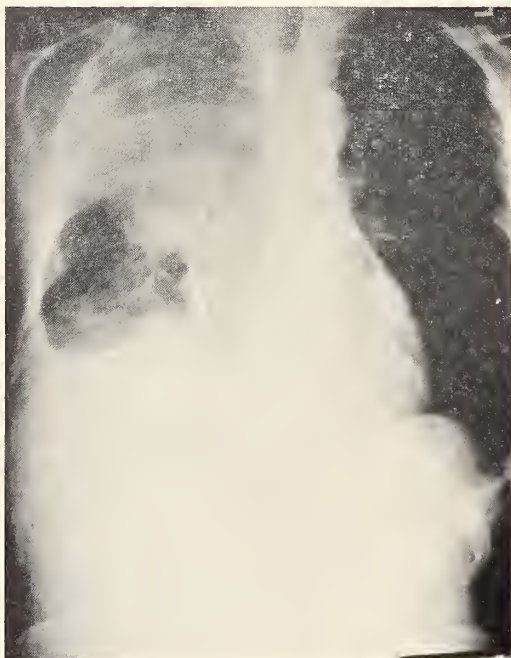


Fig. 1

This 49-year-old male complained of increasing chest pain and loss of weight over the past six months. On physical examination, the patient presented with dullness in the right upper lobe and decreased breath sounds. His facies were plethoric. There was a slight degree of cyanosis present. His neck veins were prominent and did not disappear on inspiration. There was a slight degree of facial edema. What's your diagnosis?

(Answer on page 565)

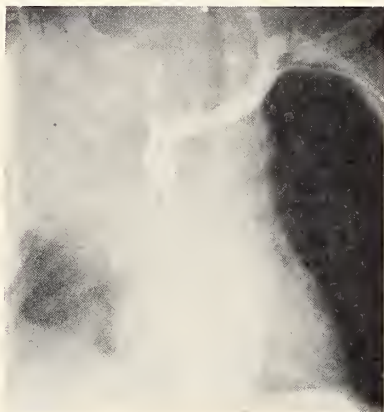


Fig. 2

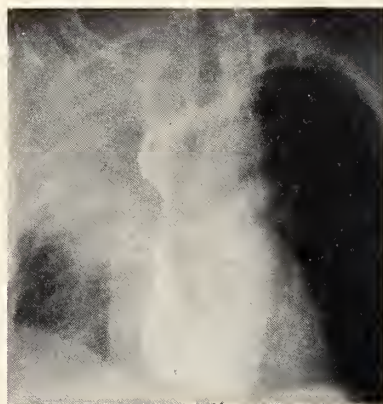


Fig. 3

Functional Interpretation of Placental Ultrastructure

By RALPH M. WYNN, M.D./CHICAGO

A major result of the ultrastructural studies of a variety of placental types has been the provision of data indicating functional adaptations of all layers of the placental membrane. In particular, the complexity of the trophoblast, the close histogenetic relation of cellular to syncytial varieties, and the correlation of histochemical and ultrastructural findings have been demonstrated. The following paragraphs will exemplify the relevance of electron microscopy to elucidation of current problems of placental morphogenesis, endocrinology and immunology.

Histologic correlations. The density of the trophoblastic nuclei, as noted by light microscopy, is explained by the high content of deoxyribonucleoprotein (DNP) particles. Cytoplasmic basophilia of the metabolically active form of trophoblast is correlated with its abundant granular endoplasmic reticulum and free ribosomes. Deposits of glycoprotein and lipid are related to the PAS-positive and sudanophilic droplets, respectively, as detected histochemically.

The so-called trophoblastic brush border appears, under the electron microscope, to comprise inconstant microvilli. Convolu-

tions of plasma membranes and formation of pinocytotic vesicles and caveolae are related to those functions of the cells that are concerned with transport of water and ions. Some of the largest vacuoles, which can be detected by light microscopy, represent dilated cisternae bounded by endoplasmic cytomembranes. It appears that all components of the placental membrane contribute to a virtually continuous system of channels from the free trophoblastic surface through basal laminae and fetal capillaries, providing a direct route for rapid transport of products of absorption and secretion.

The number of layers in the placenta fails to provide an accurate index of its histologic intimacy or of the potential ease of diffusion. For example, capillaries may indent both trophoblast and endometrium in an almost intraepithelial location. Thus, without a change in the number of cellular layers, the thickness of the placental membrane is significantly reduced.¹⁸

The Grosser scheme represents one of the most popular attempts at histological classification of placentas. It has, however, proved increasingly inadequate as knowledge of comparative placental structure and function has advanced. The original concept of a placental "barrier" has been replaced by that of a highly efficient selective membrane. The principal inadequacies of the Grosser classification involve its failure to account for the anatomic variations

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Supported in part by Grant HD 04152 from the U.S.P.H.S.*

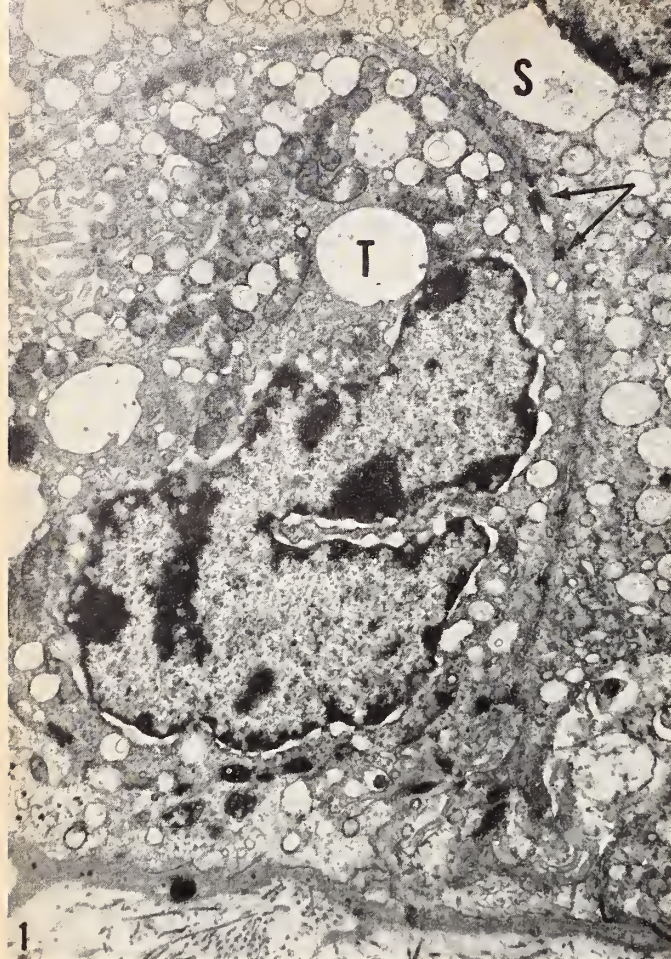


Fig. 1. Human placenta at 8 weeks' gestation, showing transitional trophoblast (T) joined by desmosomes (arrows) to syncytium (S).

within the placenta, the changes accompanying placental aging, and the accessory placental organs. The basic deficiency, however, is the implication that a reduction in number of layers of the placental "barrier" is equivalent to increased placental efficiency. Whereas the transfer of substances that cross the placenta by simple diffusion could theoretically be influenced by thickness of the barrier, the Grosser scheme fails to consider the vital activities of the highly complex placental membranes, particularly with regard to the active transfer of metabolites. The significance of the number of layers has diminished even further with the knowledge that transfer of many crucial substances, such as the respiratory gases, is dependent not on ease of diffusion so much as on limitation of flow.⁵

Evolution of the Syncytium. The origin of the syncytium has generated considerable speculation based upon the early observations of the lack of mitotic figures therein. Since the syncytium appears incapable of self-perpetuation, its derivation either from another cell or by amitotic di-

vision was postulated. In pursuing the problem, Richart¹¹ exposed placental cultures to tritiated thymidine and found, by autoradiography, the labeled trophoblast only among Langhans cells. Midgley and co-workers⁶ confirmed these findings in the pregnant Rhesus monkey, and found that the label, which at first appeared confined to the cytotrophoblast, was later detected in autoradiograms of the syncytium also. This observation was consistent with the concept that the cytotrophoblast gives rise to the syncytium. Galton provided support with his microspectrophotometric analysis of deoxyribonucleic acid (DNA) in the placental nuclei.³ The bimodal distribution of the DNA values suggested derivation from cytotrophoblast rather than amitotic division of syncytial nuclei.

Electron microscopy has provided morphologic proof of the intimate relation of the two types of trophoblast. The absence, as anticipated by light microscopy, of an intratrophoblastic basement membrane separating syncytium from Langhans cell has been confirmed. There are, moreover, desmosomes between syncytium and cytotrophoblast, suggesting an intimate relation of the two epithelial subtypes (Fig. 1). Several recent reports^{10,18} of normal and neoplastic trophoblast, furthermore, have described morphologic transitions from cellular to syncytial trophoblast via a spectrum of "intermediate" cells. The significance of these findings lies in the capacity of the placenta to form new syncytium throughout its life from cellular "reserve" elements. Whereas Langhans cells may serve as a source of energy in the early placenta by virtue of their content of glycogen, their principal function is probably to serve as a potential source of syncytium (Fig. 2). In conditions of stress, such as hypoxia, new syncytium may form more rapidly to meet the needs of the fetus, providing an excellent example of the crucial role of the

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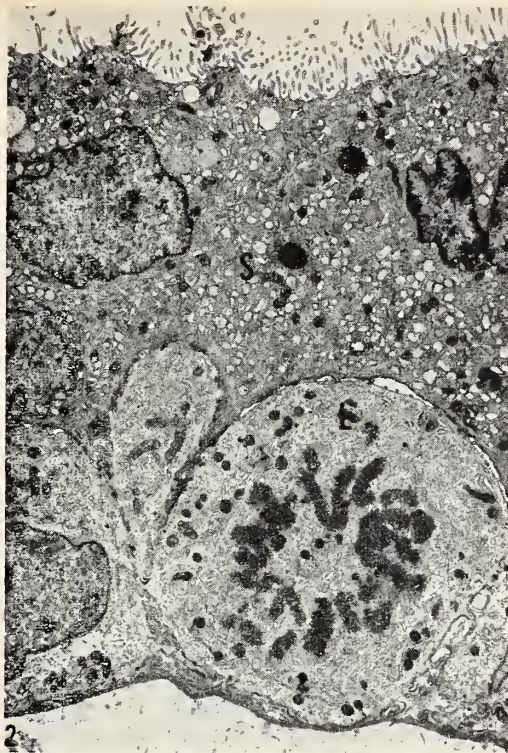


Fig. 2. Early human placenta (6 weeks' gestation) showing mitotic figure in Langhans cell (L) and syncytiotrophoblast (S).

placenta in the maintenance of fetal homeostasis.¹⁷

Placental endocrinology. The ultrastructural characterization of the various forms of trophoblast has been of aid in the problem of distinguishing concentration from production of protein and steroid hormones by the trophoblast. In their classic histological monograph on the human placenta, Wislocki and Bennett¹⁴ attributed to the syncytium the production of the steroids estrogen and progesterone, which were regarded as the basis for the phenylhydrazine reaction. The positive staining of the Langhans cells with the Periodic Acid-Schiff (PAS) reagent was considered suggestive of the localization of chorionic gonadotropin, a glycoprotein, in the cellular trophoblast. Although circumstantial evidence of the association of high levels of HCG with clinical situations in which there are increased numbers of Langhans cells has often been provided, the ultrastructural simplicity of the typical villous cytotrophoblast appeared incompatible with the production of proteins for export, a function that requires a well-developed rough-surfaced endoplasmic reticulum. In the syncytiotrophoblast, however, were found all the subcellular organelles required for the production and transport of

proteins. Immunofluorescent localization of most of the HCG to the syncytium¹⁰ supported the concept of production of both steroid and protein hormones by the syncytium. Furthermore, many of the so-called cytotrophoblastic elements that appeared, under the light microscope, to localize HCG were actually transitional ultrastructurally, suggesting maturation of endocrine activity simultaneously with the morphologic evolution of the syncytium. With the localization of the recently described placental growth hormone-prolactin to the syncytium,¹² it now appears justified to consider the syncytium the differentiated form of trophoblast, reserving for the cytotrophoblast the role of reserve, or stem, cells, the principal function of which is to form new syncytiotrophoblast.

Placental immunology. It is now generally agreed that continued survival of immunologically competent cells of differing genetic composition in immediate jux-

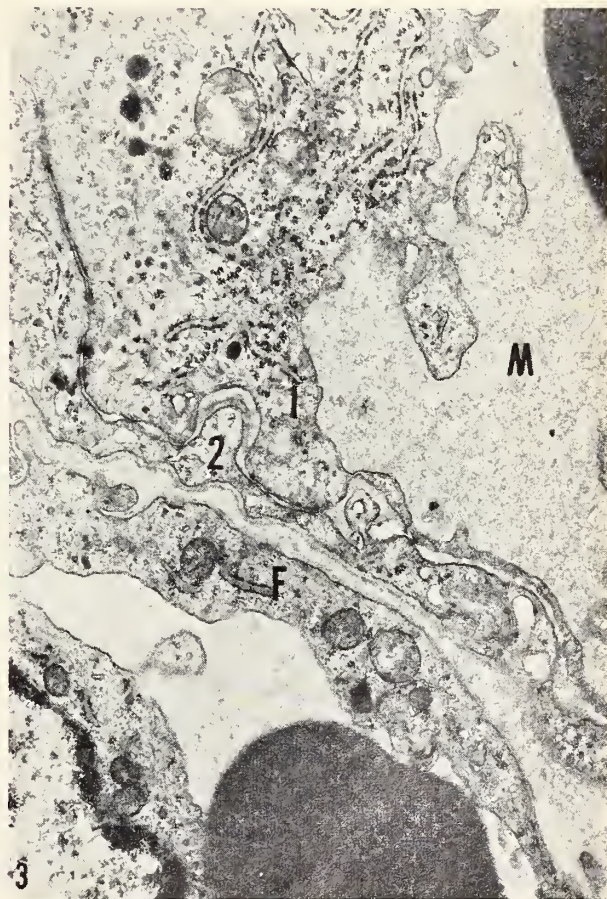


Fig. 3. Hemodichorial placenta of rabbit, showing two-layered trophoblast (1,2), fetal capillary (F), and maternal blood space (M).

taposition within the hemochorial placenta requires a physical separation of maternal and fetal tissues¹³ by a trophoblastic layer or its pericellular sialomucins. In this context it becomes highly significant that placentas formerly considered to be hemoendothelial,⁷ that is, lacking trophoblast, have been reclassified as hemochorial on the basis of electron microscopy,^{2,20} which consistently demonstrates at least one layer of trophoblast throughout most of gestation. On the basis of light microscopy, Mossman and Owers⁹ recently suggested that the placenta of the shrew *Sorex* may be endothelio-endothelial. Since in every placenta thus far examined by electron microscopy, some trophoblast, albeit thin, persists, it is therefore most likely, as Mossman⁸ readily admits, that the shrew's labyrinth will be found to retain trophoblast as well. In many of the rodent placentas, in which the membrane may be exceedingly thin, a well-defined single layer of trophoblast can be detected. It may be syncytial, as in the guinea pig, or cellular, as in the jumping mouse. In the placentas of rabbits and hares, this thin membrane

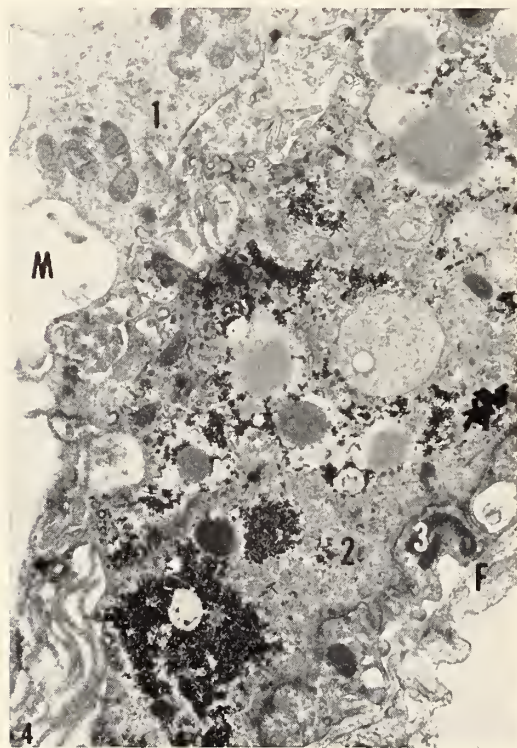


Fig. 4. Hemotrichorial placenta of hamster, showing three-layered trophoblast (1,2,3) fetal capillary (F), and maternal blood space (M).

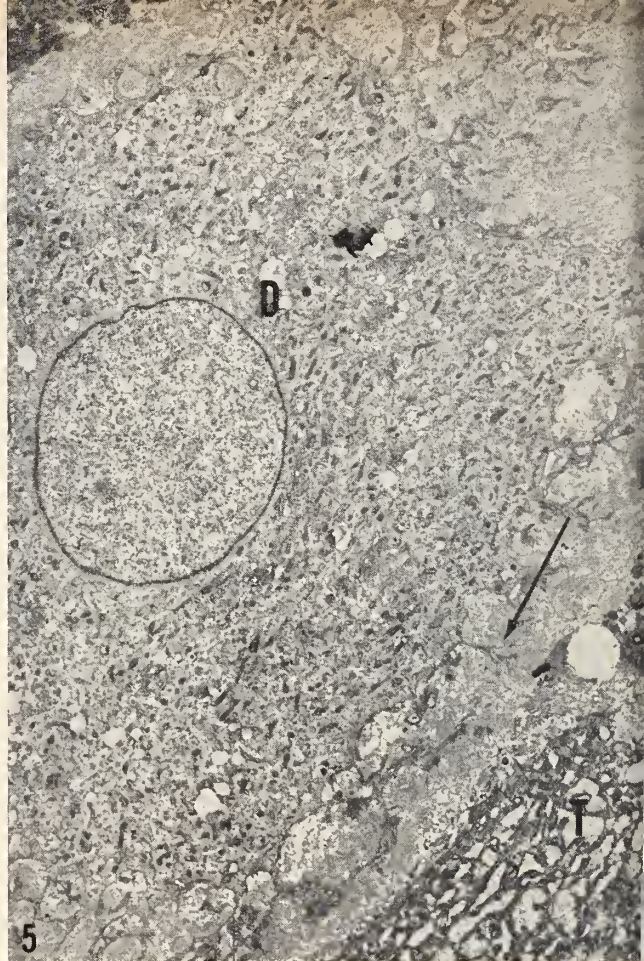


Fig. 5. Decidual cell (D) and degenerating trophoblast separated by only small amount of amorphous fibrinoid material (arrow) in invasive hydatidiform mole.

can be shown to consist of two layers of trophoblast in addition to fetal capillaries and connective tissue (Fig. 3). In the mouse, rat, and hamster, for example, electron microscopy reveals three layers of trophoblast, the hemotrichorial condition in Enders' terminology^{2,18} (Fig. 4).

The immunologic significance of the noncellular components of the placenta remains to be proved.¹⁹ Since many of the less intimate placental membranes, such as those of the ungulates, are normally devoid of fibrinoid, such histologically and histochemically demonstrable substances are most unlikely to play a significant part in placentation in general.¹⁶ The ultrastructurally detectable sialomucin coats on the microvilli and plasma membranes, however, are much more widely distributed. They therefore may, in fact, be crucial factors in the immunological protection of the "foreign" fetal tissues.⁴ Supporting evidence is provided by the recent observation that dissolution of this mucopolysaccharide calyx by neuraminidase renders the trophoblast

apparently antigenic, and therefore capable of immunologic recognition.¹ The relation of these extracellular coats of the trophoblast to the pericellular deposits of the decidua¹⁵ is not clear. In trophoblastic growths, such as the invasive hydatidiform mole, there is apparently less "fibrinoid" elaborated by the decidua.²¹ This ultrastructural observation has given rise to the speculation that perhaps the abnormal invasiveness of trophoblast in these lesions may be related to the impaired capacity of the decidua to erect a noncellular barrier. The concept of a deficient decidual reaction in placenta accreta and invasive mole, however, requires confirmation and corroboration by other techniques (Fig. 5).

In conclusion, the revelation of additional fine structure details of placental architecture during the last few years has been less impressive than the reinterpretation of the anatomic findings in accordance with concomitant advances in placental biochemistry, endocrinology and immunology. The future of placental electron microscopy thus appears very likely to lie in the ultimate synthesis of morphologic and chemical data in the burgeoning field of modern cellular biology. ◀

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Brother, Can You Spare \$1 Trillion?

You might wonder, as we enter the decade of the trillion-dollar economy, what \$1 trillion could buy. According to Columnist Sylvia Porter, with \$1 trillion you could buy every American family a home costing close to \$20,000, give every American individual a round-the-world trip, or pay for a four-year college education for 100 million students, at \$2,500 a year.

Sex Chromosome Abnormalities and Neuropsychiatric Disorders

By JANET D. ROWLEY, M.D./CHICAGO

The evidence that sex chromosome abnormalities, involving both the X and Y chromosomes, are associated with intellectual deficiency^{1,2} as well as with a variety of psychiatric disorders^{3,4} is fairly convincing. The mechanism(s) by which these abnormalities are produced is unknown. An awareness of the methods used to collect the data is essential for their proper interpretation, as well as for identification of problems that require further clarification.

Chromosomal analysis is a time-consuming procedure requiring highly-trained personnel.⁵ Large-scale surveys of normal individuals are, thus, relatively rare. Studies of buccal mucosal cells from normal females show a darkly staining nuclear mass (the Barr body or sex chromatin mass) which is absent in cells from normal males (Fig. 1). This mass represents one condensed X chromosome; the normal number of chromatin bodies is one less than the number of X chromosomes present in the cell.⁶ The buccal smear technique permits surveys of large populations, but it can only detect abnormalities involving the X chromosome.

Chromatin-Positive Males

The incidence of sex chromatin abnormalities found in various populations is



Fig. 1. Buccal mucosal cell of a normal female. The Barr body or sex chromatin mass (arrow) represents one X chromosome which is condensed during interphase. The irregularly shaped, smaller, darkly staining areas within the nucleus represent condensed chromatin of other chromosomes.

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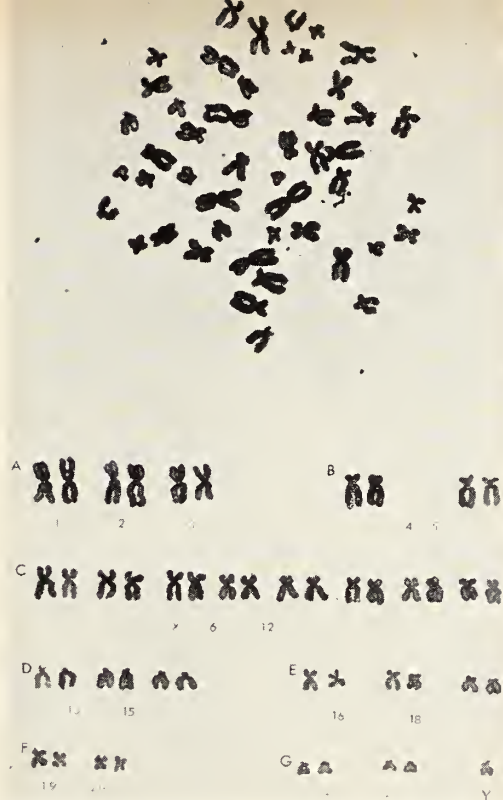


Fig. 2. (Top) Intact metaphase plate from a 52-year-old male with 47 chromosomes who clinically showed the typical features of Klinefelter's syndrome. (Bottom) Karyotype of same cell with the chromosomes arranged in seven groups of morphologically similar chromosomes. The two X chromosomes, which are morphologically indistinguishable from the remainder of the group, are included with the C group chromosomes (47, XXY).

summarized in Table I. A karyotype of the abnormality most frequently seen in chromatin-positive males, namely 47,XXY, is shown in Fig. 2. The incidence of chromatin-positive males is more than four times as great in mentally defective patients as in the newborn population. In addition, sex chromosome patterns such as XXXY and XXYY, which are not seen or only rarely seen in the newborns, comprise a significant proportion of sex chromosome abnormalities in the retarded (Table II). It has been noted that the incidence of chromatin-positive males varies with IQ, the incidence being much higher in institutions with high-grade mentally defectives. Specifically, the incidence of chromatin-positive males with an IQ 0-19 is 2.2/1000, IQ 20-49 is 9.0/1000 and IQ 50+ is 17.6/1000.^{10,11} The incidence of sex chromatin abnormalities in males in hospitals for the mentally ill falls between the control level and that of mental defectives.^{4,8} A number of factors may cause this increase, of which mental deficiency is the most obvious. One-third of the chromatin-positive males studied in one survey were mentally deficient although one-half of these had psychiatric problems as well. Epilepsy is another factor that is associated with an increased incidence of chromatin-positive males.¹² The

Table I
Incidence of Abnormal Sex Chromatin Patterns

Population	MALES			FEMALES				
	Total Number	Number Positive	Percent	Total Number	Number with Two Chromatin Bodies	Percent	Number Chromatin Negative	Percent
Newborns ^{4,7}	12,456	23	0.18	11,653	12	0.1	3	0.03
Mentally Defectives ^{2,4}	11,613	98	0.84	9,249	43	0.46	8	0.09
Mentally III ^{4,8}	13,852	75	0.54					
One Survey—Mentally III ⁴ by diagnosis	6,000	30	0.5	7,207	17	0.24	0	
Mentally Defectives	479	10	2.00	391	4	1.02		
Epilepsy	149	3	2.02	141	1	0.7		
Schizophrenia	2,895	11	0.38	2,017	6	0.3		
Other	2,477	6	0.24	3,692	5	0.14		

Table II^{9*}
Type of Chromosome Abnormality Found in Various Groups of Chromatin-Positive Males

Source	No.	XXY	XXYY	XX	XXXY	XY/XXY	Others
Newborn (13,257)	21+4†	14 (67%)	1 (5%)	0	0	6 (28%)	
Subfertile Males‡	39	36 (92%)	0	2 (5%)	0	1 (3%)	
Mental Hospital‡	24	20 (83%)	0	0	0	4 (17%)	
Mental Defectives‡	55	33 (60%)	3 (5%)	0	6 (11%)	4 (7%)	9 (17%)

*Based on Table 2.5 p. 39, ref. 9.

†Chromosomal pattern not analyzed in 4 males.

‡Total number of males examined not stated.

evidence at present suggests that there may be an increase in the incidence of abnormal sex chromatin in schizophrenic males, as compared with the general population, even when allowance is made for the broad range covered by this diagnosis.

Similar surveys for females are also included in Table I, which summarizes data on the 47,XXX female with two sex chromatin masses, as well as the 45,X female with no sex chromatin body.⁴ There appears to be four times as many XXX females in institutions for the mentally retarded, as well as three times as many 45,X females. This latter observation has been questioned because the increase is due to an excess of 45,X females found in only one series of patients.¹³ The incidence of females with two chromatin bodies who were detected in a survey of mental hospitals is about $2\frac{1}{2}$ times that of the general population; no chromatin-negative females were observed.⁴ As in the case of males in mental hospitals, much of the excess of XXX females was a result of including patients with mental deficiency in the hospital population. Schizophrenia was also a factor contributing to the excess.

Some authors question the propriety of making a diagnosis of schizophrenia in patients with sex chromosome abnormalities.¹⁴ There appears to be no doubt that additional X chromosomes exert a deleterious effect upon mental development, both intellectual as well as psychological. The effect does not seem to be mediated mainly through hormonal imbalance.⁹ It remains to be decided whether the extra X chromosomes are solely responsible or whether they exaggerate some predisposition to mental illness determined by other factors.

Abnormalities of the Y Chromosome

Regarding abnormalities of the Y chromosome (which usually affect only males), the incidence in the newborn population varies with different surveys. Since there is no simple screening procedure for their detection,* abnormalities of the Y chromosome can be identified only by karyotyping each individual in the survey. The frequency of XXY males in the newborn population

ranges from 4 in 1066¹⁵ to none in 1332,¹⁶ two other surveys finding about 1 per 1000.^{11,17} A karyotype of an XYY male is shown in Fig. 3. Chromosomal analyses of large numbers of mentally deficient individuals are rare. Most of the information on the frequency of the double Y in this population comes from an analysis of chromatin-positive males who are found to have 48 chromosomes with an XXYY karyotype.^{1,8}

The apparently increased frequency of XXYY in maximum security hospitals for the mentally retarded who also showed antisocial behavior¹⁸ led the Edinburgh group to karyotype the inmates of a Scottish hospital with two populations, one of which was mentally defective and aggressive, and the other of which was psychotic and aggressive.³ Of 197 individuals in the first group, one was XXYY and 7 were XYY



Fig. 3. (Top) Intact metaphase plate from a 7-year-old male with 47 chromosomes (first detected by Dr. Eugene Pergament, Medical Genetics Section, Michael Reese Hospital Medical Center, Chicago). **(Bottom)** Karyotype of same cell showing that it contains two Y chromosomes, and the child is thus 47, XYY.

*A technique using fluorescent acridine derivatives to stain the human Y chromosome has been reported recently^{25, 26}, and may prove to be a useful procedure for screening.

(3.5%), whereas only two XYY (and no XYY) were found in the second group of 117 patients. It was noted that all of these patients were 6 feet or over, and thus the more recent surveys have concentrated on tall males with anti-social behavior. Several different surveys, summarized in Table III, have found that from 10 to 25% of individuals who are 72" or over, and who are both mentally defective (IQ was 50 and over) and anti-social may have an XYY sex chromosome constitution. Conversely, it should be emphasized that from 75 to 90%

IQ. Similarly, when evaluating the relationship of the YY chromosomal pattern and behavior, it is crucial to know whether height, some degree of mental deficiency, or aggressive behavior were factors, singly or together, in selecting the population. Even in comparing prison populations, it is important to know if the institution was organized as an open unit with a fair amount of freedom and was, therefore, likely to have few problem individuals, or if it was a maximum security institution designed for the care of difficult-to-manage

Table III
The Occurrence of the YY Chromosomal Pattern in Various Groups of Males

Source	No.	Chromatin +	XYY	YY
Newborn ^{4,7}	13,257	25 (0.2%)	1 (0.08%)	
Mentally Defective ¹	2,607	28 (1.1%)	2 (0.08%)	
Mentally Defective and Anti-Social Behavior ¹⁸	942	21 (2.2%)	7 (0.74%)	
Mentally Defective and Hard to Manage ⁸	760	15 (2.0%)		
Mentally Defective and Anti-Social Behavior ³	197	2 (1.0%)	1 (0.50%)	7 (3.5%)
Psychotic and Aggressive ³	117	1 (1.0%)	0	2 (1.7%)
Prison and Psychiatric Problems ¹⁹	204	3 (1.5%)		2 (1.0%)
Mentally Defective and Aggressive ²⁰	72" +	50		12 (24.0%)
Mentally Ill and Aggressive ²⁰	72" +	50		4 (8.0%)
Criminal ²⁰	72" +	24		2 (8.3%)
Mentally Ill ²⁰	72" +	30		0
Normal ²⁰	72" +	30		0
Prison ²¹	69" +	34		4 (11.8%)
Prison ²²	72" +	45		1 (2.2%)

of these same groups are chromosomally normal. Jacobs²³ analyzed the chromosomes of 606 mentally defective males with few behavior problems who were unselected for height, and found no XYY individuals. Present studies suggest that the XYY male appears to be the black sheep, standing out as the erring son in an otherwise reasonably well-adjusted family.²⁴ Since the incidence of the XYY male in the general population has not been definitely established, it is difficult to determine the significance of the apparent excess of these individuals in the tall, mentally retarded, anti-social portion of the prison population.

Evaluation Essentials

A serious handicap in comparing results of different surveys is the fact that they may relate to populations that are superficially similar but intrinsically different. Thus, the incidence of chromatin-positive males in an institution for the mentally defective depends quite clearly on whether there is any selection for higher or lower

inmates.

For proper evaluation of the data obtained from surveys, we need information on the mental and psychosocial development of unselected XYY and XYY males, such as those identified in the newborn surveys. If the incidence of XYY is approximately 1/1000 newborn males, then there are about 100,000 XYY males in the United States. It is apparent that some indeterminate fraction of them are normally functioning members of society. Identification of the factors which, when coupled with a sex chromosome abnormality, produce mental deficiency, mental illness or aggressive, anti-social behavior will require several decades of careful observation and documentation.

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(Continued on page 562)

Medical Services in South Africa

BY HAROLD C. VORIS, M.D./CHICAGO

This is a report of personal observations on the medical facilities of the Republic of South Africa. Drs. Virgil T. DeVault, head of the International Section of the American Medical Association, Harold Sofield, Emeritus Professor of Orthopedic Surgery at Northwestern University, Robert Long, Professor of Obstetrics and Gynecology at the University of Louisville Medical School and I were guests of the Republic of South Africa for a three weeks tour of that country. The stated purpose of our visit was to visit their medical schools, principal hospitals and medical research centers. However, our many conversations with leaders of the medical profession, educators and public officials gave us a great deal of information about the economic, social, political and educational systems of that country. This is a factual report and I will confine my statements to what I personally saw and heard.

Our host was the Department of Public Information. Our tour was well planned and organized and our guide, Mr. Seig Dahlke, and his superiors were most cooperative in changing our schedule so that we could meet the people we wished. The hospitality, courtesy and kindness that we encountered everywhere made the trip outstanding.

Our itinerary was crowded. At times we felt rushed and overworked but in retrospect I would have been disappointed to have missed anything on our schedule. We arrived on September 16, at the Jans Smuts Airport which serves both Johannesburg and Pretoria. Three days were spent in Pretoria. Next we visited Umtata, the Capital of the Transkei an African Homeland,

for two days. This area has its own government and police force. It is 16,500 square miles in extent and has a population of approximately 1,500,000. In this area are 1,600 schools, 4,000 teachers and 270,000 pupils.

Next we spent a day at East London, four days at Capetown and two days at Durban, the capital of the province of Natal. This was followed by an extra-curricular highlight of two days in the Kruger National Park. Then we visited the Bantu University College of the North.

We returned to Johannesburg for a short visit of two days. Finally we were taken to Welkom in the Orange Free State for a day. This included a visit to one of the leading gold mines and the large Bureau of Mines hospital there. Return to Pretoria and departure on October 4, completed our strenuous 19 day schedule.

Harold C. Voris, M.D., is Chairman, Section on Neurological Surgery, Mercy Hospital Medical Center and Chief of the Section of Neurosurgery, Hines, VA Hospital. He holds an M.D. from Rush Medical College and a Ph.D. from the University of Chicago. In addition he has been awarded the D.Sc. from Hanover College. In addition to his staff positions, Dr. Voris is Clinical Professor of Neurosurgery at the University of Illinois Medical School and consultant at two other sites. He is board certified in neurology and in neurosurgery. This paper was originally presented at the 1968 Annual ISMS Convention.



General Impressions

South Africa must be classified as a developed country, the only one in all Africa. Its economy was initially agricultural. Later mining of gold, diamonds, coal and iron became important. Now industrialization is proceeding at a rapid pace. The three and one-half million whites control the economy and the political and social structure and intend to continue this control.

The non-white population includes approximately 12,750,000 Bantu, 1,860,000 Cape Colored and 560,000 Asiatics (Indians). The so-called Bantu include a number of tribes of which the principal are the Nguni including the Xhosa, Zulu, Sivazi, Sotho, Venda and Shangana and the Tsonga. The Xhosa and Zulu are the most numerous. These two groups alone number nearly six million. These people differ anthropologically from the Central African Negro. Their blood type ratios vary and they lack the factor for sickle cell anemia that the Central African peoples possess. A large proportion of the Bantu are still in the tribal stage and subject to the rule of their chiefs. In theory they are confined to the Bantu Homelands which are being further enlarged (at the expense of displacing white farmers, often after several generations of land ownership). In practice there are many Bantu outside of their homelands, either on contract labor in the mines or residing in so-called townships adjacent to the larger cities and industrial areas.

The stated aim of the government is to eventually have the Bantu peoples all residing in their homelands which would be bordered by industrial areas where they could find employment. Because of the dependence on the Bantu as a general labor source this ideal does not appear attainable in the foreseeable future. Large sums of money are being spent on education and medical facilities for the Bantu and this burden is borne by the white taxpayer.

The Cape Colored peoples are the descendants of the Bushman and Hottentot peoples of the Cape with an admixture of white blood. They are on the whole better educated and at a higher economic level than the Bantu. They have entered the building trades extensively. There are a number of business establishments owned by Coloureds and there is a Coloured

branch of the Cape Chamber of Commerce.

The Asiatics (Indians) originally came to Natal as indentured labor on the sugar plantations. They have greatly prospered, are now mostly merchants and small storekeepers and relatively well-to-do, even wealthy. They are most numerous in the Durban area.

Wild life is now essentially confined to the game parks. The Kruger National Park is the largest but there are a number of smaller ones. The Kruger Park covers 8,000 square miles and has a surprisingly high population of large game animals. The bird life is also rich and varied. I was surprised to find that hunting as a sport seems to have practically disappeared from the Republic of South Africa. The only large game animals are now confined to the game parks and apparently little or no effort has been made to develop the small game; waterfowl and upland bird shooting that is so popular in the United States is little practiced. The hunters of South Africa now go abroad to Mozambique, Kenya and Tanzania to exercise their sport!

Medical Services

The medical services of South Africa will be discussed under the headings of Public Health, Hospital Facilities (with specific attention to neurosurgical facilities) and Research Centers. Our tour began with a visit to the Department of Health in Pretoria. Dr. C. A. M. Murray, Secretary for Health, described the activities of his department and furnished us with a number of statistical reports. I was impressed with the degree of control of contagious disease in all population groups. For example, the 1967 data showed no cases of typhus in any group except the Bantu where the rate was 0.1 per 100,000 population. The incidence of malaria was 4.2 per 100,000 in the whites and 4.6 for the Bantu. There was an incidence of 12.6 cases of diphtheria per 100,000 population in the Bantu and only 4.0 in the whites. The rate of typhoid fever was 4.1 for whites and 26.5 for the Bantu. Poliomyelitis incidence was 0.1 for whites and 0.4 for the Bantu. The greatest problem is tuberculosis. This disease has an incidence of 34.9 per 100,000 population in the white, 436.5 in the colored, 204.9 in the Asiatic (Indian) and 460.7 in the Bantu. The

figures for tuberculosis are essentially the same for 1965, 1966 and 1967. On the other hand, the rate of typhoid fever in the Bantu dropped from 37.9 in 1965, to 26.5 in 1967.

In the course of our visits to various hospitals and medical centers we learned that intracranial tuberculosis is relatively uncommon and generally occurs as tuberculosis meningitis. Spinal tuberculosis is, on the other hand, very common and is a frequent cause of paraplegia in the Bantu.

The hospitals are generally large, well equipped and efficiently run. Wards predominate and the facilities, while generally good and sufficient, are not luxurious by American standards. White and nonwhite patients have separate wards but the same operating rooms are used for both and there is no separation of medical staff or diagnostic facilities for the two groups. The teaching hospitals were the most impressive because of the general high quality of staff and facilities and the interest in research. This is particularly true of the Karl Bremer Hospital of the Stellenbosch University Medical School and the Groote Schuur Hospital of the Capetown University Medical School, both in Capetown. As might be expected, interest in organ transplants is high. Everyone is aware of the four human cardiac transplants by Dr. Barnard at the Groote Schuur Hospital. However, at the Karl Bremer Hospital the physically small Experimental Surgical Laboratory has performed several hundred kidney transplants, 10 heart transplants and 10 liver transplants in the baboon. The primate center of this institution is affiliated with Johns Hopkins University.

A good example of a large non-teaching hospital for both whites and nonwhites is the Wentworth Hospital at Durban. The present capacity of this institution is 623 beds but extensive enlargement is in progress. The beds are equally divided between white and nonwhite. Equipment is excellent—for example a Linde Cryogenic Unit in the neurosurgery department.

Exclusively black hospitals are common. The nonwhite medical school at Durban has a 2,000 bed teaching hospital. We only briefly visited this institution but it seemed physically equal to other teaching hospitals and was apparently well organized and operated.

At Johannesburg we visited two large Bantu hospitals. The first, the Natalsspruit Bantu Hospital has 800 beds and is the hospital for 38,000 inhabitants of two townships. Three hundred major operations are done monthly in eight operating rooms and 1,300 patients are seen each month in the outpatient department. The Baragwanath Bantu Hospital is the teaching hospital of the medical school, has 2,217 beds and serves the Someto Bantu township. This township has 600,000 inhabitants occupying 120,000 homes and covers an area of 30 square miles. There are 120 schools including 12 high schools, three sports stadia and an Olympic size swimming pool. The hospital treats 600-800 burns of children yearly and performs 2,500 major operations monthly in 10 operating rooms (exclusive of gynecological and emergency operating rooms). There is a nursing school of 100 students. These students become nursing sisters after graduation.

The Mission hospitals, especially in the Bantu homelands, are an important source of medical care. In the Transkei there are two provincial general hospitals and one tuberculosis hospital with 500 beds each. There are 12 mission hospitals (eight of which are supported by the Dutch Reformed Church) with a total capacity of 1,500 beds. These latter hospitals are scattered throughout the area so that all the inhabitants are within a few miles of a hospital.

Finally, the mining hospitals must be mentioned. They are owned and operated by the mining companies. For example, the Anglo-American Corporation of South Africa Limited provides 27 hospitals for the care of 166,000 African employees. Their largest hospital, and said to be the largest industrial hospital in the Southern Hemisphere, is the Ernest Oppenheimer Hospital at Welkom in the Orange Free State. This is a modern, four story building with 900 beds, including women's, children's and maternity sections. Equipment is up-to-date in every respect and includes an artificial kidney. Peritoneal dialysis is also used for renal failure. The physiotherapy and occupational therapy departments were outstanding, especially the rehabilitation of paraplegics. Since these people seldom survive very long if they are returned to their homes in the

tribal areas, they are given above ground employment in various sedentary occupations by the mining companies. This enlightened attitude toward the problem of the paraplegic in industry is admirable.

The Bantu often look to their native medicine men (witch doctors) for medical care. This is especially true in the tribal areas (native homelands). While the medical facilities offered nonwhites are not quantitatively equal to those for whites, they are equal qualitatively and probably are as extensive as the Bantu will use at present.

It is government policy to interfere as little as possible with native culture and customs and this hampers the effort to bring European medicine to the Bantu.

Neurosurgery

I was especially interested in the development of neurosurgery and its availability to the public. As elsewhere, this is a relatively young specialty and in some respects has not yet come of age in South Africa. It is still largely confined to the larger cities, so neurosurgical centers tend to be large with the neurosurgical staff gaining a great deal of experience especially with trauma and intracranial neoplasms.

For example, at the Groote Schuur Hospital there is a neurosurgical service of 100 beds with over 500 major procedures annually. The staff consists of three full time and three part-time surgeons. Some 60% of the cases are due to trauma. The department is well organized, teaching conferences are well conducted and stimulating and this group is doing an outstanding job in both the care of the patient and the training of neurosurgeons. On the other hand, the Karl Bremer Hospital, equally large and outstanding from a general standpoint, has only a relatively small neurosurgical service with no full time staff and no training program.

There is a good neurosurgical service at Johannesburg, again with a training program. This group has 75 beds at the Princess Hospital and 40 beds at the Baragwanath Bantu Hospital. I visited this unit and found it well arranged with an excellent operating room and equipment. This service as well as the one at the Princess Hospital is headed by Dr. Robert Lipschitz.

Finally, the neurosurgical services in

Durban must be mentioned. These are under the direction of Dr. M. J. Joubert. There are two other members of the department and three registrars. The Faculty of Medicine of the University of Natal (Durban Medical School) has two teaching hospitals, the Wentworth with over 600 beds equally divided between white and nonwhite patients and the King Edward VIII Hospital with over 2,000 beds for nonwhite patients. The neurosurgical service is largely concentrated at the Wentworth Hospital with 102 beds for neurological and neurosurgical patients but there are 25 neurosurgical beds at the King Edward VIII Hospital.

Research

The research facilities of the Republic of South Africa are impressive. First, the South African Council for Scientific and Industrial Research Center (CSIR) outside of Pretoria is so large it would take several days to visit completely. The annual budget is 17.8 million dollars (U.S.) with 1.4 million allotted to medical research. A medical research committee, composed largely of medical scientists, reviews and decides on applications for grants. During our brief visit we saw only the department for hospital planning and nutritional research centers. In this latter there is a large primate colony. Extensive study is being carried out on a toxin extracted from a mold that affects corn (mealies), peanuts (ground nuts), and millet stored under improper conditions. This toxin fed to rats will cause carcinoma of the liver, a common malignancy in the Bantu peoples who use the foods mentioned above extensively and often store them under conditions facilitating the development of mold.

Another important research center is the South African Institute for Medical Research at Johannesburg under the direction of Dr. J. H. S. Gear. This institute was founded in 1912 and opened in 1914. Its original purpose was to study the high incidence of silicosis in Bantu miners. This is no longer a problem. It was of historical interest to find that Dr. W. C. Gorgas of the Panama Canal Zone was a registered visitor to this institute in 1915.

Studies on the incidence of various diseases in the Bantu miners continue. It was interesting to hear of the relatively high

incidence of benign hypertension in the Bantu with a contrasting low incidence of this disease in the Indian population. Contrary to expectation, the Bantu tend to have low blood cholesterol values, the Indians high.

The poliomyelitis research institute is an important branch of the South African Institute for Medical Research. Sophisticated investigations are being carried out on various viruses including the carcinogenic viruses. I might mention that the cytomegalic virus has been responsible for the death of several organ transplant patients, including the first cardiac transplant.

Research in organ transplants is being primarily carried out at Capetown in both the Groote Schuur and the Karl Bremer Hospitals. The research laboratories at both of the institutions have large primate colonies and the basic experimental work on organ transplants is carried out in primates. In the surgical laboratory at the Karl Bremer Hospital, we saw simultaneous cardiac and renal transplants on the baboon and in the same room a corneal transplant in progress, also on a baboon.

A brief visit to the Onderstepoort Veterinary Research Institute near Pretoria was enlightening. The professional and technical staffs number 228 with a total of 930 employees. This institution is primarily concerned with veterinary medicine but in its ramifications, important work on the control of malaria, sleeping sickness, tick-borne diseases and a number of viral diseases has helped the Department of Health in its efforts to control these diseases.

The extent of this operation is illustrated by the population of over 4,000 large animals (including 2,500 sheep) and some 425,000 small animals (over 400,000 mice). Research and vaccine production requires 4,000 eggs daily!

Medical Education

It is not my purpose to discuss education in South Africa in general but a brief outline of the educational calendar will serve to orient the reader to the statements about medical education.

Ordinarily a student spends eight years in the primary schools and four in a secondary school before matriculation in a University. This is modified for the non-

whites—at least for the Bantu. Here, after the eight years of primary school, three years of secondary school include a preparatory year and two years of high school. At this point the student may enter a teachers training school for two years and is then able to teach in a primary school. Instead of teachers training school he may take two more years of high school and then obtain a matriculation certificate for a university.

There are five medical schools in the Republic of South Africa. These are Capetown, Stellenbosch, Johannesburg, Pretoria and Durban. The latter is a nonwhite school but nonwhite students are also admitted at Capetown and Johannesburg. The medical course requires six years of which the first is a basic science year. However, at Durban (University of Natal) the student has to take a preliminary year of study unless he can pass an examination that admits him to the first year of Medicine.

The degree of Bachelor of Medicine (M.B.) or Bachelor of Surgery (Ch.B.) is awarded at the end of the medical course. One of these degrees plus a year of internship is required before the graduate can register as a medical practitioner. In 1967, there were 2,105 medical students, 594 interns, 9,639 medical practitioners and 2,206 registered specialists in the Republic of South Africa.

Now we come to the training of the specialist, and specifically of the neurosurgeon. After the year of internship the young physician can become a registrar (resident) in the specialty of his choice. However, he is generally encouraged to practice for a year or more before starting training as a specialist. In any case, to become a recognized specialist in neurosurgery he has to spend five years. At least two of these are initially spent in general surgery. However, at Capetown the neurosurgical trainee takes an initial or primary degree in general surgery. This requires three years. He then takes three and one-half years of neurological surgery and is then eligible for a secondary degree in that specialty.

Neurosurgical training with the bestowal of a degree in the speciality can be obtained in Pretoria, Capetown and two centers in Johannesburg. Training in neuro-

surgery is given at Durban but the University of Natal does not award a degree in that specialty.

Currently there are 33 registered neurosurgical specialists in the Union of South Africa. Of these 25 are concentrated in Johannesburg, Capetown, Durban, and Pretoria, the four largest cities, with no less than 13 in Johannesburg. The ratio of neurosurgeons to total population (18,733,000) is 1:56,800. This is less than in the United States, Europe, Australia and some Latin American countries. It is much higher than in any other African or Asian country except Japan. It appears certain that neurosurgery is entering the period of rapid development and growth that has been seen in Europe and much of the Western Hemisphere.

Summary

The Republic of South Africa is a developed country with a stable government, a well based economy and excellent educational facilities which are being made available to all segments of the population. Medical services are good and in some areas outstanding. There is great interest in medical research and outstanding work is being done. It has a pleasant climate and great mineral resources with the exception

of oil, and diligent search is being made for this.

On the minus side agriculture is hampered by inadequate rainfall except in the south and eastern costal area. The price of gold, the most important mineral wealth, is set by factors which South Africa can hardly hope to control. Most important of all, is the problem of race relations which will continue to be the most pressing and difficult to solve. The enlightened attempts to bring education and health to the nonwhites, especially the Bantu, not only increase the numerical superiority of the nonwhite but will almost surely increase his demands for equality and then majority control. Avoiding this may still be possible in the twentieth century, but what about the twenty-first?

The visitor to South Africa can only admire the resolution and determination of this young nation and wish that their problems were less overwhelming. Time will tell whether the Republic of South Africa can become two racially separate but politically and economically equal societies or whether it will be a bitter and bloody battleground. As one becomes acquainted with the country and its peoples, both white and nonwhite, he can only fervently hope for the success of the former alternative.

Obituaries

***Boris Berkman**, Chicago, died November 19 at the age of 76. He was a member of the ISMS 50-Year Club.

***William B. Campbell**, Chicago, died in March at the age of 77. He was a fellow of the International College of Surgeons.

***Murray M. Feldman**, Lincolnwood, died March 23 at the age of 49. He was on the staff of Walther Memorial Hospital.

***Irving Handwerger**, Chicago, died March 19 at the age of 55. He was past president of the Garfield Park Hospital staff.

***Erwin L. Hirsley**, Western Springs, died March 23 at the age of 61. He was a retired radiologist.

***Wendell Kane**, Herrin, died March 7 at the age of 60. He was past president of the Williamson County Medical Society.

***Charles P. Renner**, Belleville, died March 15 at the age of 89. He was a mem-

ber of the ISMS Fifty-Year Club.

Maurice P. Seidner, Chicago, died March 14 at the age of 83.

***Ernest D. Seymour**, Streator, died March 21 at the age of 92. He was a member of the ISMS Fifty-Year Club.

***J. Thomas Slattery**, Lincolnwood, died March 19 at the age of 61. He was a past president of the Chicago Medical-Legal Jurisprudence Society.

***Caesar J. Sweitzer, Sr.**, Wilmette, died March 31 at the age of 59, while on a cruise around the Bahama Islands.

Frank F. Trombly, Chicago, died March 14 at the age of 86.

***Gustav Zechel**, Chicago, died March 9 while on vacation in Hawaii. He was 70 years of age.

*Indicates Member of Illinois State Medical Society.



THE DOCTOR'S LIBRARY

ADLER'S TEXTBOOK OF OPHTHALMOLOGY, Harold G. Scheie, M.D. and Daniel M. Albert, M.D., W. B. Saunders Company, Philadelphia, 1969, 509 pages, 565 figures, \$17.50.

It is particularly pleasing to me to review the eighth edition of this classic textbook of ophthalmology since the first edition was written by a former chief of ophthalmology at Northwestern University, Dr. Sanford Gilford. This first edition appeared in 1938, a second in 1941, and the third and final edition under the aegis of Dr. Gilford in 1945. On his untimely death, the publishers asked Dr. Francis Adler—then chief of ophthalmology at the University of Pennsylvania—to take over the task of revising successive editions. The dramatic advances in ophthalmology over the next 20 years necessitated a complete re-writing of the book and these changes are reflected in editions four to seven which Dr. Adler supervised and indeed completely rewrote. The revisions were so complete that this text properly became known as **ADLER'S TEXTBOOK OF OPHTHALMOLOGY**. Since medicine progresses and it became apparent that with the changing curricula in medical schools and the cry of students for relevance, a new edition was needed.

This has now appeared as the eighth edition and the mantle of authorship has fallen onto the shoulders of Dr. Adler's successor at the University of Pennsylvania, Dr. Harold Scheie. He with the collaboration of Dr. Albert has again completely revised this standard text. The most obvious change is the inclusion of a vast number of color plates (38 to be exact, containing 275 illustrations). This feature is particularly valuable since with the establishment of core curricula and individual "tracks," the clinical exposure of students to ophthalmology will probably be reduced. This text will serve as a valuable reference source to this group as well as to beginning residents in ophthalmology.

In addition there is great emphasis on basic topics in ophthalmology such as embryology, genetics, physiology and pharmacology. These sections as well as several others have been written by special consultants which further adds to the value of the text.

All in all, this is a complete and first-class revision of what was already a fine textbook of ophthalmology. It is highly recommended to all readers of this journal.

David Shoch, M.D.

BING'S LOCAL DIAGNOSIS IN NEUROLOGICAL DISEASES. 15th Edition. C. V. Mosby Co., St. Louis, 1969.

This monumental volume of 600 pages and 32 chapters still contains the kernel of Professor Bing's text as well as much of his illustrative material, yet bears little resemblance to the original edition. This edition is wisely dedicated to Professor Robert Wartenberg, a great teacher and a close friend of Bing's. It was through him Haymaker's first translation came about.

Some of the contributors to this volume include Bernard S. Epstien, Jorge Huertar, William F. Mehler, Hans R. Mueller, Francis Schuller and Paul Yakovlev.

Adequate references follow each chapter. The anatomy text with illustrations is

very adequate in helping localize neurologic diseases; the localization of segments involved in spinal cord lesion versus peripheral nerve lesion are well illustrated; the anatomical and physiological basis of clinical neurological lesions are easily discerned; the chapter on electromyography, though brief, is ample. Unfortunately the Foradic (is not a sinusoidal current) examination is not even mentioned. It is still a rapid and inexpensive aid in electrodiagnosis.

The various spinal-brainstem clinical syndromes are well described and illustrated.

For completeness, there is one chapter on trauma, brain shifts, tumor and hematomas; roentgenographic aids are simple and adequate for both spinal cord and

cerebral lesions; there is a separate chapter on echoencephalography, electroencephalography as well as radioactive-nuclide scanning.

As in previous volumes this book is highly recommended for neurologic specialists as well as students in neurology.

Alex J. Arieff, M.D.

VOL. 3—MEDICAL STAMPS. Handbook No. 63. E. Willis Hainlen, M.D., editor.

American Topical Association, Inc., Milwaukee, Wisconsin, 1968, illustrations, \$5.00.

VOL. 4—PRIVATE DIE PROPRIETARY MEDICAL STAMPS. Handbook No. 66. George B. Griffenhagen, M.D., American Topical Association, Milwaukee, Wisconsin, illustrations, \$4.00.

These two volumes are recommended for those who are interested in medical stamps.

T. R. Van Dellen, M.D.

Clinics for Crippled Children Scheduled

Twenty-five clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois, Division of Services for Crippled Children. The Division will count 18 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be five special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

June 3 Carmi—Carmi Township Hospital
 June 3 Hinsdale—Hinsdale Sanitarium
 June 3 Rock Island Cerebral Palsy—3808 Eighth Avenue
 June 4 Effingham—St. Anthony Memorial Hospital
 June 4 Lake County Cardiac—Victory Memorial Hospital
 June 9 Peoria—St. Francis Children's Hospital
 June 9 East St. Louis—Christian Welfare Hospital

June 10 Champaign-Urbana — McKinley Hospital
 June 11 Rockford—St. Anthony Hospital
 June 11 Springfield General—St. John's Hospital
 June 12 Chicago Heights Cardiac — St. James Hospital
 June 16 Belleville—St. Elizabeth's Hospital
 June 16 Rock Island Area General—Moline Public Hospital
 June 17 Chicago Heights General — St. James Hospital
 June 18 Bloomington—St. Joseph's Hospital
 June 18 Elmhurst Cardiac — Memorial Hospital of DuPage County
 June 22 Peoria Cardiac—St. Francis Children's Hospital
 June 23 Peoria — St. Francis Children's Hospital
 June 23 East St. Louis—Christian Welfare Hospital
 June 23 Danville—Lake View Hospital
 June 24 Aurora—Copley Memorial Hospital
 June 24 Springfield Pediatric Neurology —Diocesan Center
 June 26 Chicago Heights Cardiac — St. James Hospital
 June 26 Evanston—St. Francis Hospital
 June 30 Alton—Alton Memorial Hospital

The Right to Fail

"Free enterprise includes the freedom to fail. It is in rigged economies where competition is discouraged and inefficiency is coddled that the rickshaw and the toted sack will last the longest."—Jenkin Lloyd Jones, president, Chamber of Commerce of the United States.

The negative power of anxiety...

**This man thinks he may
never work again.**



The patient who has had a myocardial infarction is usually advised by his physician to avoid emotional excitement. All too often his family, acutely concerned, transmits its anxiety to him, urging him to "rest, rest."

How anxiety may interfere

In a study of 336 males who had suffered at least one myocardial infarction, Sigler¹ reports that manual workers showed the lowest percentage of patients returning to work, compared to clerical workers, business and professional men. The author notes that in many cases the mere apprehension that "return to work would shorten life prevents the patient from resuming activities." It is also well known that emotional disturbance is probably the most common cause of cardiac disability in postinfarction cases.¹

The anxiety factor in both *coronary* and *precoronary* patients has recently been discussed by Thomas,² who suggests: "Intensive investigation of the sources and kinds of anxiety, and how destructive forms of anxiety can be identified and relieved may be the next important step in the prevention of coronary heart disease."

Relief of anxiety with Librium® (chlordiazepoxide HCl) often proves a valuable adjunct to medical counsel, reassurance and the total management program; may help prevent the postcoronary patient from regressing into a state of invalidism.

As an adjunct in cardiovascular therapy, Librium® (chlordiazepoxide HCl): Quickly relieves anxiety of mild to severe degree in most cases. Helps expedite cooperation in therapeutic regimen. May be used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, antihypertensive agents

and diuretics. By relieving anxiety, helps encourage productive activities. Has a wide margin of safety and, in proper maintenance dosage, seldom impairs mental acuity or ability to function. Often effective in extended therapy, usually without diminution of effect or need for increase in dosage—in protracted use, periodic blood counts and liver function tests are advisable.

References: 1. Sigler, L. H.: *Geriatrics*, 22:(9) 97, 1967. 2. Thomas, C. B.: *Johns Hopkins Med. J.*, 122:69, 1968.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating

drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

To curb anxiety in the postcoronary patient adjunctive

Librium®
(chlordiazepoxide HCl)
10-mg capsules



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Rx Products

Index

Achrocidin	473	Neo-Synephrine	474
Achromycin	3rd Cover	Winthrop Laboratories	
Achrostatin	567	Obedrin-LA715L	543
Lederle Laboratories		Semed Pharmaceutical Div.,	
		S. E. Massengill Co.	
Aventyl HCL	552-553	Flagyl	2nd Cover
Eli Lilly and Company		G. D. Searle & Co.	
Dicarbosil	564	Quinamm/AVC	549, 550
Arch Laboratories		National Drug Co.	
Doxidan	481	Salutensin	496-497
Hoechst Pharmaceutical Co.		Bristol Laboratories	
Equanil	493, 494	Sinequan	485-488
Wyeth Laboratories		Pfizer Laboratories Div.,	
		Pfizer & Co.	
Cordran Tape	498	StomAseptine	547
Eli Lilly and Company		Harccliffe Laboratories	
Indocin	478-480	Tepanil	495
Merck, Sharp & Dohme, Inc.		National Drug Co.	
Librium	540-541	Vasodilan CVD	466-467
Roche Laboratories		Mead Johnson Laboratories	
Mylanta	544	Valium	Back Cover
Stuart Pharmaceuticals Div.,		Roche Laboratories	
Atlas Chemical Industries, Inc.		Vibramycin	556-558
Neosporin Ointment	491	Pfizer Laboratories, Div.,	
Burroughs Wellcome & Co.		Pfizer & Co.	

A Good Foundation

The first story had its origin in 1943 when a local English community I was viting on a weekend pass happened to be the site of a Luftwaffe bombing raid which, for all practical purposes, destroyed this quaint English town even to the point of ripping up its sewers and burning almost all of the village buildings.

As for the destroyed English village: I revisited it recently out of sentiment and curiosity and found essentially the same quaint-appearing place that had existed prior to its wartime destruction—even, one might suspect, as to the antique sewerage system and drainage for storms that had existed since Roman Days. In an effort to learn why the town had been rebuilt as it was rather than changed I discovered that while all involved could not agree on present or future construction they had all agreed upon the past plans. Is there a moral here for those of us who would destroy and build rather than build upon the good foundations of what we have? ("Public-Private Partnership: Its Impact Upon Physicians and Their Professional Associates," Carroll L. Witten, *Bull. N. Y. Acad. Med.* [Nov.] 1969, pgs. 1171 and 1175.)

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

ISMS Asks Change In Usury Laws

ISMS has urged state legislators to exempt medical student loan funds from the state's usury law. The State Society said an 8% rate ceiling in Illinois has made the AMA's Student Loan Program economically unfeasible for participating banks. This ceiling is threatening to cut off educational funds to 300 physicians in Illinois, and comes at a time when the doctor shortage is already critical. A bill introduced in the legislature would permit higher interest rates for the AMA student loan program. Principal sponsors of the bill are Senators E. B. Groen (R-Pekin) and Alan J. Dixon (D-Belleveille).

IDPA Costs Soar: Up 5 Times in Decade

More than five times as many dollars were spent by the Illinois Department of Public Aid (IDPA) for medical care in 1969, than in 1959. According to a recent IDPA report, a whopping \$184 million was spent in fiscal 1969, compared to \$35.3 million ten years earlier. The IDPA report pointed out that the rising cost spiral became more pronounced in 1966, with the advent of Medicare and Medicaid. During this 10 year period, IDPA reported general hospital care costs advanced 466%, and nursing home costs rose 172%. Appropriations for fiscal 1970 include: Medical Assistance program—\$233.7 million; Aid to Dependent Children—\$222.5 million; Assistance to the Aged, Blind or Disabled—\$72.4 million; and General Assistance—\$56 million. IDPA expects the upward spiral on medical costs to continue into 1970, as medical programs are expanded.

4 So. Illinois Counties Top Public Aid Roles

Four Southern Illinois counties led the state in the number of public aid recipients per 1,000 population during 1969, according to IDPA statistics. Of these four, Pulaski County was highest with a monthly average of 249; Alexander County was next with an average of 207; third was Gallatin County with 157, and Hardin with 144. The state's most populated county—Cook—averaged 66. The lowest number of IDPA recipients per 1,000 population was listed by DuPage County with 5, and Kendall County with 4.5.

New Boss Named For Regional Med Program

Morton C. Creditor, M.D., 46, associate director for Community and Social Medicine at Michael Reese Hospital and Medical Center, has been named Executive Director and Program Coordinator of the Illinois Regional Medical Program. Dr. Creditor began his new duties April 1. He succeeds Dr. Wright Adams who has served since the program began in 1967. Dr. Adams is moving to Alabama.

New Pamphlet Answers Federal Charges

A new ISMS pamphlet that "tells it like it is" about Washington's attempts to blame MDs for soaring Medicare and Medicaid costs, is now available to ISMS members free of charge. Attractively illustrated and designed to fit business envelopes, this pamphlet uses statistics to answer major allegations leveled at physicians by federal officials. The pamphlet can be placed in reception rooms and should be included in billing statements. It is available in quantity, upon request from the ISMS Division of Public Relations and Economics.

YOUR INSURANCE QUESTIONS


QUESTION: Part of the resident training program in our local hospital requires a type of preceptor training for these young men. Our residents accompany us on calls and work with us in our offices. Do you feel that those of us covered by ISMS Professional Liability Insurance need be concerned about the necessity of a different type of malpractice coverage?

ANSWER: All members of the medical profession should be concerned about the possibility of a liability loss arising out of the situation described above. The ISMS Professional Liability Insurance policy covers the insured physician for liability accruing out of negligent professional acts of men for whom he is legally responsible. No coverage extends to the young men assisting you. No revision in your malpractice liability is necessary, however, we do urge that sufficient limits of liability protection be carried by the physician.

Do you have a question of general interest on any ISMS-sponsored insurance program: Retirement Investment, Keogh, Group Disability, Group Major Medical, Professional Liability (Malpractice)? Send it to this column: "Your ISMS Insurance Questions," Illinois Medical Journal, 360 North Michigan Avenue, Chicago, Illinois 60601. The column is a service of the ISMS Committee on Medical Economics and Insurance.

Number of Poor in U. S. Declining

The number of "poor" in the U. S. declined about two million last year, according to Bureau of Census, U. S. Department of Commerce. The reduction, which included about 800,000 persons of races other than white, chiefly Negro, brought the total of persons living in poverty down to 25.4 million at the end of 1968, compared with 28.5 million in 1966 and 39.5 million in 1959.



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Many women find they occasionally have excessive discharge, spotting and increased mucus secretion, which can result in unpleasant odor. Douching with StomAseptine cleanses, deodorizes, soothes and relieves itching . . . and helps prevent embarrassment.

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Wall Tension May Contribute to Atherosclerosis

Increased tension on the walls of arteries may be a significant contributing factor to the development of atherosclerosis and other forms of artery disease, scientists have found during an intensive study of arteries at The University of Chicago. The study, under the direction of Dr. Seymour Glagov, Associate Professor of Pathology, has also contributed to the understanding of how arteries are constructed and how the arterial wall is nourished by supplementary small blood vessels. One phase of the study has brought up the possibility that new channels resembling large arteries might be induced to develop in connective tissue to substitute for defective arteries.

Working with several other investigators, Dr. Glagov began his U.S. Public Health Service sponsored research nine years ago by studying the differences between arteries supplying the heart and those supplying the kidneys. The main renal arteries seldom show signs of atherosclerosis, the buildup of substances which harden the arteries. By contrast, arteries supplying the heart are frequently attacked.

The main difference could be the tension in the walls of the vessels. The average tension in the arteries of the heart is greater than those supplying the kidneys; the heart closes off its own circulation each time it contracts, tending to cause the arteries to dilate. The flow through the kidneys is not normally closed off in this way.

Proceeding from this it was found that by changing the flow in the kidneys and lungs of animals, the occurrence of atherosclerosis in the vessels supplying those organs was caused.

If such differences in vessel function could lead to differences in susceptibility to disease, the structure of normal arteries might also be different depending on the function they perform. By examining the aortas of hundreds of animals and humans under conditions similar to those prevailing during life, the physicians made a number of interesting findings.

It found that aortas owe their strength and resiliency to the fact that they are constructed much like fiberglass. In addition to smooth muscle cells, the aortic wall contains interlacing strands of two types of fibers, elastin and collagen. Elastin stretches

like rubber and collagen is very strong, like tendon, but stretches very little. The collagen gives the aorta its strength, and the elastin distributes the tensions through the wall uniformly.

It was also found that while the total number of comparable layers in each aorta remains about the same throughout adult life, the number and size of the layers increase during growth. Somehow, the growing vessel wall, increasing its tension as its diameter increases, thickens by addition of new layers of elastin, collagen and cells to strengthen the walls.

As evidence was accumulating that tension related to vessel development, it was decided to experiment to see if tension could stimulate the production of tissue layers experimentally.

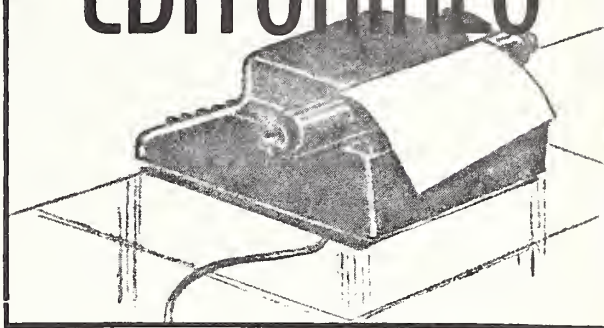
Flexible pulsating tubes were inserted into guinea pigs and rats. In a few days layers of tissue resembling blood vessel walls formed around the tubes.

In this phase of the work, further experiments are under way to determine how the undifferentiated cells begin to form layers as they cluster around the pulsating tubes. By observing how the layers are built, insight will be gained into how cells differentiate to serve varying functions.

Another interesting aspect of this research led to insight into a question which has puzzled researchers. Small blood vessels called vasa vasorum nourish very large arteries such as the aorta. However, not all animals have these small vessels in their aortic walls and the penetration seemed to vary from species to species. If the number of layers in an aorta were more than 29, vasa vasorum were evident from the 29th layer out. Apparently, nourishment from the lumen of the arteries is adequate up to 29 layers. Beyond this, adjacent small intramural vessels are needed for both growth and differentiation. Dr. Glagov indicated that the vasa vasorum which appear in larger mammals may be important factors in arterial disease.

"We still must determine how arterial wall growth and differentiation are controlled," said Dr. Glagov. "If we can do this, we may be able to find out how excessive tension predisposes vessels to injury and disease."

EDITORIALS



DR. TALBOTT RETIRES

We were sorry to read of the retirement of Dr. John H. Talbott from the editorship of the *Journal of the American Medical Association*. Dr. Talbott will not be inactive and will continue his editorial chores for the AMA. He deserves much credit for having elevated *JAMA* to a position of esteem among national and international medical publications. We also were honored to have Dr. Talbott as a member of the Illinois Medical Society during his decade of editorship.

Dr. Talbott is responsible for many improvements in the *Journal*, including the colorful, historical pictures on its covers. In addition, our official organ has always been a target for outside critics but external pressures never modified his editorial decisions.

Dr. Talbott was born in Grinnell, Iowa, and attended Grinnell College where he received a bachelor of science degree and in 1946 an honorary doctorate (D.Sc.). In 1929, he was graduated from Harvard Medical School and served his internship at Presbyterian Hospital in New York. He returned to Harvard, and in 1946, accepted the professorship of medicine at the University of Buffalo and physician-in-chief of the Buffalo General Hospital. He came to the American Medical Association in 1959.

During World War II he attained the rank of Colonel in the Medical Corps AUS. He was decorated with the Legion of Merit for his research at the Climatic Research Laboratory. Dr. Talbott is a recognized authority on gout.

T. R. Van Dellen, M.D.

INTERPROFESSIONAL COMMUNICATION

Are you aware of what dentists are doing?

No. They're not doing anything wrong. But are you aware of their treatment techniques, their use of prescription items, fluoride treatments, and so on?

The case of a 7-year-old girl lacking enamel development (hypocalcification) illustrates a point. When queried on what course might be followed, the physician indicated that it was a dental problem. He suggested consulting a dentist. The dentist in turn wanted to know what the physician recommended. The patient became the medium through which these professionals communicated.

Are physicians not concerned with the total health picture of the individual? Can they communicate with other professionals?

This is a matter each practitioner should consider. Good communication between professionals will render many benefits for all concerned, and in many mutual activities the cooperation will lead to further forward steps.

RAO

LEE REGULATION

In *JAMA's* "75 Years Ago" column, a Senator O'Dwyer introduced a bill into the Illinois State Senate to regulate the fees of physicians and surgeons. The maximum fee for any surgical operation was pegged at \$100. Members of the press credited the Senator with being the first person to bring this subject to the attention of the law.

Apparently some member of the fourth estate neglected to look up the records be-

cause professional fees, including lawyers' fees, were regulated since early times by the government. The "rapacity of lawyers" was controlled for centuries before the medical profession was included (Naples 8th century). Needless to say, the astute legislators refused to go along with O'Dwyer. (Regulation of Doctors' Fees, *JAMA*, "75 Years Ago" March 2, 1895), 211:9 (Mar. 2) 1970, page 1151).

T. R. Van Dellen, M.D.

**Some days she can't seem
to function...**





Membership Forum

April 3, 1970

Dear Sir;

I read over with interest the article on "Severe Status Asthmaticus," which appeared in the January issue. The article is very interesting and very worthwhile, with one exception. In my opinion, no matter what precautions you are taking, the use of strong sedatives is extremely dangerous. I am referring especially to Demerol and Thorazine. The respiration is already decreased and anything which further decreases the breathing ability is forbidden. Everyone knows that morphine, Demerol, and Dilaudid slow the breathing. I therefore object, and object very strongly, against the use of both of those drugs.

I have had personal experience with bronchial asthma over many years and since 1930, no patient of mine has ever received an injection of morphine or Demerol while they were having an attack of asthma.

Sincerely,
Leon Unger, M.D.

Dear Doctor VanDellen: March 24, 1970

I would like to express our appreciation to you and your staff for the February, 1970, issue of the *Journal*. The cover was superb, and the pictures of the Medical Center included in my article were very eye-catching and interesting. I have received many comments on the very nice effect of the issue.

We are very earnestly striving to do our part and more to help solve the State's manpower problems, and the February issue should help us immeasurably. We do appreciate the effort that went into the February issue.

Cordially yours,
Alexander M. Schmidt, M.D.
Dean

Ed. note: Membership Forum is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.



THE POPULATION BOMB by Dr. Paul R. Ehrlich, Ballantine Books, Inc., New York, New York, \$.95.

Over-population is now the dominant problem in all our personal, national, and international planning, so states Dr. Paul Ehrlich in his book.

Dr. Ehrlich presents all the different facets of the problem—air, food, water, birth control, death control, our total environment—and provides a realistic evaluation of the remaining options.

Ehrlich's concern with over population and its effect on air and water pollution

should be of particular interest to all Illinois residents in the light of Governor Ogilvie's recent request for a \$750,000,000 pollution referendum.

Schools, politicians, and mass media only touch the edge of this most crucial problem. Ehrlich is convinced that "the only real hope in this crisis lies in the grass-roots activities of individuals."

It is therefore very important that each individual be aware of the problem and what he can do. We recommend this easily read 200 page book as a guide to further involvement.

A high-contrast, black and white artistic photograph. In the upper right, a box of 'Pfizer 100' is partially visible. Below it, a medical syringe with '1/2' markings is shown. To the left of the syringe is a small petri dish containing a culture of bacteria. In the lower center, a crumpled piece of paper is visible. At the bottom right, there is a small alarm clock with the number '24' on its face. The overall composition is dramatic and emphasizes medical themes.

Pfizer
100

rapid
absorption
may surpass
tetracycline
I.M. blood
levels within
one hour

real broad spectrum,
including
susceptible strains of
Pneumococcus*
"Staph"* "Strep"*
H. influenzae*
M. pneumoniae (PPLO)*
N. gonorrhoeae*

low incidence
of diarrhea

outstanding record
of clinical success

therapeutic blood levels
usually persisting
around-the-clock



Field Position Filled

Mr. Philip Thomsen II, has been appointed as the new ISMS Field Service Representative. The position, previously approved by the Board, will provide greater liaison between the ISMS headquarters and the county medical societies.

Call for Usual and Customary by DVR

In acting upon the report of the Council on Economics and Governmental Health Programs, The Board directed that an inquiry be sent to Mr. Alfred Slicer, director of the Division of Vocational Rehabilitation, asking for a definite answer as to when and how DVR will recognize Usual and Customary Fees.

Medical Director for Nursing Homes

The Illinois Department of Public Health will be asked to strengthen minimum standards for nursing homes by requiring appointment of a medical director on a consulting basis. Action came on a recommendation of the Committee on Aging which believes that the patients in nursing homes need a backup source of medical care when their own physicians are not available. Dr. Franklin Yoder, department director, concurred in the recommendation and felt such a requirement would be feasible.

Clarification of Procedures in Nursing Homes

On recommendation of the Committee on Aging, the Medical Legal Council will be asked to examine the position of ISMS on death certification in nursing homes and suggest modifications if necessary. The action was taken because nursing homes frequently call mortuaries before medical examination of the deceased, thus resulting in the signing of death certificates after the body has been embalmed.

In related action the Board approved a study by the Medical Legal Council to clarify the laws governing nurses in the taking of blood samples, initiating intravenous feedings, etc. in nursing homes when not under the immediate supervision of a physician.

Distribution of Physical Therapy Guidelines

A communication will be sent to all hospitals and all extended care facilities in the state of Illinois relative to the proper use of physical therapy services. If possible, this communication will be issued jointly by the Illinois Hospital Association. This action is in line with the development of guidelines for physical therapy services by the Committee on Rehabilitation as approved at the January meeting.

Continuing Medical Education

George Miller, M.D., director, Center for Education Development, University of Illinois Medical Center, outlined the University's plan for a total statewide program on Continuing Medical Education. The latest teaching techniques will be utilized and all available educational resources will be coordinated through a Council on Continuing Medical Education. The Council will consist of 15 representatives from the Illinois State Medi-

cal Society and 10 representatives from the medical schools. The Illinois Regional Medical Program is expected to be involved as well as the Illinois Academy of General Practice and other groups.

Funding for the program will be provided by the state through the University, the Illinois Regional Medical Program, and other supplemental sources. Dr. Miller suggested that ISMS consider a dues assessment of \$20 per member with the first \$20 of any fees charged under the program waived for ISMS members. The Board expressed support of the program within the realm of its resources and adopted a motion to the effect that this matter be referred to the House of Delegates with a recommendation that it authorize a dues assessment of \$20 per member for this purpose.

Liability Program Rate Increase

Upon recommendation of the Insurance Committee, a modest increase in the Society sponsored professional liability insurance plan was approved effective June 1. The increase, requested by the carrier, Employers Fire Insurance Company, is in line with general increases recommended by the Insurance Rating Bureau and the actions of other companies. The plan was started in June, 1968, and currently has about 1,100 physicians enrolled. The plan administrator is Parker Aleshire and Company, Skokie, Illinois.

Annual Meeting—1971

Upon recommendation of the Executive Committee, the Board voted to schedule the Annual Meeting for 1971 at the Arlington Park Towers Hotel. The hotel is located adjacent to the Arlington Park Race Track in the northwest Chicago suburb of Arlington Heights. The action was taken following extensive study of available convention sites and the many factors involved in obtaining satisfactory accommodations. The move to suburbia is in line with similar action taken by other groups.

Operation Grassroots

A plan developed by the Public Relations Council, to refute charges stemming from the U. S. Senate Finance Committee Staff Report, was approved. The program is in line with a similar program recommended by AMA entitled "Operation Grassroots". News releases, other news media sources, and speakers will be utilized to set the record straight.

Health Care Coordinator

Albert Snoke, M.D., recently appointed coordinator of Health Services for the state, commented on his position and role. He indicated an interest in coordinating services, not operating programs. He called for a revitalization of activities and accomplishment of tasks within the framework of presently existing organizations.

In other actions, the Board—

- Approved cooperation with the AMA and the Chicago Medical Society in replacing the female mannequin exhibit at the Museum of Science and Industry, necessary funds (\$7,500) to come from

- the IMJ Improvement Grant in the Foundation;
- Voted to present a resolution to the House of Delegates asking that undesignated AMA-ERF funds of Illinois physicians be divided among Illinois medical schools, rather than all U. S. medical schools;
 - Agreed to cooperate with the Auxiliary in requesting the Governor to proclaim Bicycle Safety Week during April, 1970;
 - Approved ISMS's co-sponsorship of the Annual School Health Conference of the Department of Public Instruction;
 - Endorsed cooperation with the Illinois Society for Prevention of Blindness in establishing a screening program with a Mobile Glaucoma Screening Unit;
 - Approved a request for travel expenses for four SAMA representatives to attend the SAMA Philadelphia convention, funds for this being budgeted in the SAMA Advisory Committee;
 - Established a Committee on Ear, Nose and Throat Health, to be placed under the Council on Legislation, to study noise pollution effects and maintain an awareness in such concerns as the licensing of hearing aid dealers;
 - Approved transportation expenses for AMA delegation members to attend a special meeting called to specifically discuss the Himler Report;
 - Referred to the Council on Economics and Governmental Health Programs a suggested computerized billing service for physicians presented by the representative of the Indecon Corporation.

Approvals and appointments, the board—

- Appointed to the Committee on Allied Health Education:
 - Eugene P. Johnson, Casey
 - James D. Eggers, Jr., Westchester
 - Lawrence L. Hirsch, Chicago
 - Richard M. Magraw, Chicago
 - Donald E. Rager, Peoria
 - Sheldon Waldstein, Northbrook
 - Donald Frey, HCCI, Consultant
 - Israel Light, Chicago Medical School, Consultant
- Designated Dr. Fred Z. White and Dr. J. Ernest Breed as official ISMS representatives to the AMA Congress on Socio-Economics of Health Care;
- Appointed Dr. W. Fullerton, Sparta, representative to the Annual School Health Conference of the Department of Public Instruction;
- Named Dr. Julius Kowalski, Princeton, and Dr. Edwin Lee, Springfield, as nominees for the Department of Public Health Emergency Medical Services Committee;
- Appointed Dr. E. Piszczek to attend a Conference on Pollution, to be held in Canada.

Population to Double by 2000

"It will be necessary to build a city the size of Jersey City or Tulsa every month for the next 30 years to house the urban population, which will double from 140,000,000 to 280,000,000."—Arch N. Booth, executive vice president, Chamber of Commerce of the United States.

Sex Chromosome Abnormalities

(Continued from page 531)

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Precautions Taken Against Lassa Fever

Precautions are being taken by the Illinois Department of Public Health to prevent a deadly viral fever from infecting state residents, Dr. Franklin D. Yoder, director of the Department stated.

Lassa fever, a new strain of viral infection which, at present, is confined to a relatively small area in central Nigeria, Africa, has been reported in two laboratory workers doing research on the disease in the United States. Other than that, no cases have been reported.

Dr. Yoder voiced concern over the possibility of the viral infection entering the state through O'Hare International Airport and other airports with international traffic.

"Passengers entering the country from affected areas of Nigeria will be put under close surveillance, according to public health officials at O'Hare Airport," he explained.

Thus far no passengers from the affected areas of Nigeria have passed through O'Hare Airport. Dr. Yoder and Dr. Mason, deputy director of the National Communicable Disease Center in Atlanta, Ga. said that no cultures of the virus would be brought into Illinois without the joint approval of the National Communicable Disease Center and the Illinois Department of Public Health.

Hysterectomies Lead To Unchanged or Better Sex Lives

A Northwestern gynecologist who reviewed the cases of 317 private patients on whom he had performed gynecologic surgery found that 267 reported no subsequent change in their sexual reactions.

"Forty stated that their sex life was better," reported Dr. John W. Huffman, Northwestern University professor of obstetrics and gynecology. "Ten patients reported a decrease in their sexual reactions."

The average length of time since Huffman had performed a major gynecological operation on the patients whose cases he reviewed was eight years.

Dr. Huffman's findings were published in a recent issue of *Medical Aspects of Human Sexuality*. He is a member of the attending staffs at Passavant Memorial Hospital and Children's Memorial Hospital, Chicago.

"It is my impression that removal of a breast is a far more traumatic experience and endangers the woman's feminine self-image more than removal of any one or all of the genital organs," Huffman commented.

The 40 women who reported postoperative improvement in their sexual reactions had an improved sense of well-being because they no longer had prolonged episodes of heavy genital bleeding, were freed of pelvic discomfort, or no longer feared pregnancy or uterine cancer.

Three women out of 167 cases of vaginal hysterectomy had pain in coitus from

vaginal scarring and narrow vaginal canals, the inescapable result of extensive reconstructive surgery. Two older women out of 139 who had complete abdominal hysterectomies developed a dislike of intercourse due to atrophic vaginitis, said Huffman. One of five women who had clitorectomies was greatly disturbed by the altered physical appearance of her genitalia.

"Three of the remaining four women who reported a decrease or loss in their sexual reactions after gynecological surgery demonstrated well-defined traits indicating emotional instability and immaturity."

Had these traits been discovered preoperatively, education of the patient by the gynecologist or psychiatric treatment might have helped them avoid unhappy postoperative sexual experiences, according to Huffman.

Physicians should tell prospective patients what hysterectomies will and will not do, he remarked. Only two of six current medical textbooks that he examined mentioned the possible emotional effects of hysterectomy on women.

"A major reason why women suffer unnecessary emotional distress before and after gynecologic surgery is unsolicited but freely given consultations by tea-table and over-the-fence 'gynecologists,'" said Huffman.

"Their list of the presumed sequelae of hysterectomy makes the black plague sound like the sniffles."

U.S. War Losses in Vietnam

By January 1, 1970, U.S. battle deaths in the Vietnam War had passed 40,000. This figure includes not only those killed in action, but also those who died of wounds, and the known dead among the men originally reported as captured or missing.

The battle deaths in the Vietnam War exceed those in the Korean War by nearly 6,400 and are about a seventh of the U.S. battle losses during World War II.

Over the period 1961-1969, nonbattle deaths, therefore deaths from disease and nonbattle injuries among the troops in Vietnam, totaled more than 7,000. It should be kept in mind that the seriously ill in Vietnam were for the most part promptly

evacuated home and many of them may have died in the U.S.

The very low death rate from disease among U.S. troops in the battle zone reflects both the high standards of physical fitness of the young men selected for service in the armed forces, and the efficacy of our military medical services in Vietnam.

The Surgeon General of the U.S. Army has reported that the percentage of the wounded in Vietnam who survived after reaching medical facilities has been about 97.5%. This record has been achieved due to the rapid evacuation by helicopter of many seriously wounded personnel to hospitals while still alive.

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(Continued from page 490)

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Big Cities Jobless Rate Improves

The jobless rate in 20 largest cities last year improved more, and is lower than, the national average. BLS survey shows unemployment dropped to 3.4% from 3.9% in 1967. National average dropped to 3.6% from 3.8%.

"Heart power is the strength of America. Hate power is the weakness of the world."
—Vince Lombardi, head coach, Washington Redskins.

THE VIEW BOX

(Continued from page 522)

DIAGNOSIS:

The patient had a carcinoma of the right upper lobe with superior vena caval obstruction. A catheter was inserted into the left brachiocephalic vein and 50cc of Angio-conray was injected. An almost complete occlusion of the superior vena cava with a filling defect in the proximal portion is noted, apparently the result of either clot formation or tumor invasion. On Figure 2, there is demonstrated an invasion of the right pulmonary artery with complete occlusion. These findings had practical value to the chest surgeons in that they elected to radiate this patient rather than attempt to resect the lesion. Bronchoscopy confirmed a squamous cell carcinoma of the right upper lobe bronchus. The value of a venous angiocardigraphic study in such a case is obvious in a therapeutic approach to such a case.

C.M.S. World Medical Association Trip

The Chicago Medical Society has secured 80 seats on a scheduled flight of Lufthansa, the German Airline, for the forthcoming trip to the World Medical Association Assembly, which will be held August 16-22, 1970, in Oslo, Norway.

A deposit of \$150 per person, made payable to C.M.S. World Medical Association Trip, and mailed to Chicago Medical Society, Att: Dr. Lull, 310 S. Michigan Ave., Chicago, Ill. 60604, will assure you a seat on this first-come, first-serve basis. The balance of \$130 is due prior to June 15.

Departure time is August 12, 6:15 p.m., Flight #431, and the return flight from Frankfurt is Sept. 3, 1:00 p.m., Flight #430.

Full information about the meeting and housing may be obtained from the World Medical Association, 10 Columbus Circle, New York, New York 10019. May 1, is the deadline to apply.

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An invaluable kit, "An Aid to Speakers," may be the key to your individual success and/or the success of your speakers program. It contains a veritable wealth of source materials, ranging from generalized speeches aimed at lay audiences to numerous, up-to-date training tips. Physicians may obtain single copies free of charge by directing their requests to the Officers Services Department. Quantities of up to 50 are made available to state and county medical societies sponsoring formal speakers programs.

Car Violence

Every week traffic accidents in the United States cause more than 1,000 deaths and about 36,000 injuries.

If that was the human cost of fighting in Vietnam or violence in the streets of our cities, it is not difficult to imagine the extent and intensity of the public's outcry. Investigative commissions would be appointed, Congressional hearings would be scheduled, and the White House would be the scene of top-level conferences.

But traffic fatalities? The automobile first became a lethal weapon about 60 years ago, and Americans have grown accustomed to bloodspattered roads. They react to the growing death rate with callous indifference, as though this is the price we must pay for progress.

We may need safer cars, improved highways, and better traffic laws. But what we need most are motorists who put a high value on human life. The Biblical injunction against killing also applies to men and women who get behind steering wheels of high-powered autos.

(The Lutheran Witness)

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Rhinocytology and Its Diagnostic Possibilities in Allergy <i>Lucia Fischer-Pap, M.D.</i>	611
Adaptation of Cardiac Catheterization Techniques for Insertion of Intravascular Cardiac Pacemakers <i>Thomas Baffes, M.D., William Blazek, M.D., and Irving J. Adatto, M.D.</i>	616
Reading and Learning Problems—Ophthalmological Management <i>Lawrence J. Lawson, M.D.</i>	623
Sustaining the Mood to Diet <i>Frank L. Bigsby, M.D.</i>	630

SURGICAL GRAND ROUNDS

Retroperitoneal Mass	603
----------------------------	-----

SPECIAL ARTICLE

Health Care in the 70's <i>Jack L. Gibbs, M.D.</i>	643
---	-----

MEDICAL PROGRESS

Therapy for AHF and PTC Hemophilia, Part II <i>Ruth A. Seeler, M.D.</i>	598
--	-----

CUMULATIVE INDEX, Volume 137	651
------------------------------------	-----

FEATURES

The President's Page	584
Clinics for Crippled Children	597
The Doctor's Library	609
The View Box	610
Editorials	615
Public Affairs Library	622
Obituaries	622
New Pharmaceutical Specialties	627
Illinois Medical Assistants Association	628
Physicians Placement Service	629
Socio-Economic News	635
Meeting Memos	656

(cover story on page 582)

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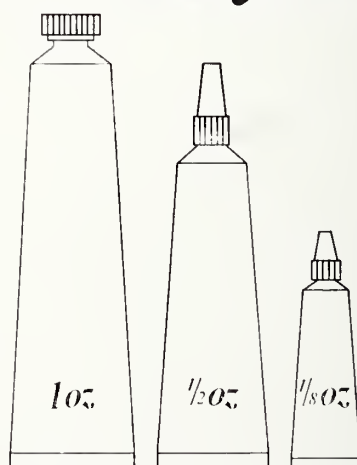
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1. Correct group and subscriber number as shown on your patient's Blue Shield Identification Card. (Do not include the codes shown on the card).
2. Correct spelling of patient's and subscriber's names.
3. Correct age of the patient.
4. Designate place of service (hospital inpatient, hospital outpatient, office, home).
5. Include dates of service, including date of admission and discharge from the hospital; date surgery was performed, if any; and number of daily hospital visits, if for medical care.
6. Indicate if an injury occurred at patient's place of employment.
7. Give details as to diagnosis, standard name of operation, if any, and sufficient descriptions, for example:

Vein Ligations: Stripping, multiple resections, both greater and lesser saphenous, unilateral or bilateral.

Lacerations: Location, length, depth and identify vessels, muscles and tendons repaired, if any.

(A copy of the operative report attached to the Physician's Service Report may be used).

8. If any unusual situations are encountered, please describe them.
9. Check only the type of service you personally rendered indicating date(s) and description of the service(s). If other physicians have also rendered service, each must submit his own Physician's Service Report.

5 Millionth Federal Employee Member Honored

The five millionth member of Blue Cross and Blue Shield Federal employees health benefit group, David W. Garrett, was honored May 6 at a luncheon attended by Federal dignitaries in Washington, D.C.

Garrett is employed in the Office of Manned Space Flight of the National Aeronautics and Space Administration.

Garrett, his wife and two-year-old daughter are covered by a comprehensive high option program that provides comprehensive benefits for hospitalization, surgery and medical treatment. It also makes provision for costs associated with unusually prolonged and severe illness up to a ceiling of \$50,000.

In a brief ceremony, Joseph E. Harvey, Vice President and Director of the Blue Cross and Blue Shield Federal Employee Program, presented Garrett with a specially designed Identification Card.

Representing the National Association of Blue Shield Plans was its President, John W. Castellucci.

In commenting on the occasion, Castellucci said:

"Today, we are not merely recognizing this young man and his family as constituting the five millionth member. Nor must we use it as an occasion to merely bask in self congratulation. Instead, we must recognize this milestone as representing the even greater challenges that lie ahead. Then we must re-dedicate ourselves to providing the kind of service that, not only made it possible to enroll five million members in the first place, but that also makes us worthy of such an overwhelming vote of confidence."

More than 65% of Federal employees have chosen the Blue Cross and Blue Shield Plans over 15 other approved health insurance carriers. Of the 5,000,000 members enrolled nationally, almost 200,000 are served by the Blue Shield Plan of Illinois Medical Service. The broad scope of basic coverage is written on the Usual and Customary basis of payment for those choosing the high option plan.

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Services in Extended Care Facilities

An extended care facility provides a wide range of services. When your patient's "condition is such that it medically justifies continuous Skilled Nursing Services and the need for such services constitutes the primary purpose of the total care furnished, he is receiving a level of care which is covered by Medicare."

The following examples of services frequently rendered in an extended care facility and their usual skill classification will aid in determining which services are considered covered.

Administration of Medication:—Medications given by intravenous or intramuscular injections usually require skilled services. The frequency of injections would be particularly significant in determining whether the patient needs continuous skilled nursing care. Injections which can usually be self-administered—for example, the well-regulated diabetic who receives a daily insulin injection—do not require skilled services. Oral medications which require immediate changes in dosages because of sudden undesirable side effects or reactions should be administered to the patient and observed by licensed nurses. This is a skilled service. When a prolonged regimen of oral drug therapy is undertaken, the need for the continued presence of skilled nursing personnel can be presumed but only during the period in which the routine is being established and changes in dosage cannot be anticipated or accomplished by unskilled personnel.

The administration of eye drops and topical ointments (including those required following cataract surgery) is not considered a skilled service. In some states, institutionalized patients must receive all medications from licensed nurses; this fact, however, would not make that administration of oral medication a skilled service when the same type of medications are frequently prescribed for home use without skilled personnel being present.

Levine tube and gastrostomy feeding:—These feedings must be properly prepared and administered. Supervision and observation by licensed nurses are required, thus making this procedure a skilled service.

Naso-pharyngeal aspiration:—The services and observations required for such care constitute skilled nursing care.

Colostomy or ileostomy:—Skilled service might be required during the immediate post-operative period following a newly created or revised opening. The need for such care should be documented by the physician's and nurse's notes. Maintenance care of this condition can usually be performed by the patient or by a person without professional training and usually would not require skilled services.

Catheters:—The insertion or the replacement of urethral catheters constitute skilled services. Repeated catheterizations during the immediate post-operative period following abdominal surgery could, with a few other skilled services, constitute continuous skilled nursing care. Routine services in connection with indwelling bladder catheters would not require skilled care. Catheters used in other parts of the body, such as bile ducts, and the chest cavity, require skilled care.

Incontinence:—General methods of treating incontinence, such as the use of diapers and rubber sheets, are not skilled services. Secondary skin problems resulting from incontinence may require special treatment. The physician's orders should indicate the treatment required and should be noted in the patient's record.

Skin care:—Existence of extensive ducubiti or other widespread skin disorders may necessitate skilled care. The physician's orders for treating the skin (rather than diagnosis) would be the principal indication of whether skilled care is required.

Routine prophylactic and palliative skin care, such as bathing and the application of creams, do not constitute skilled services. Presence of a small ducubitus ulcer, rash, or some other relatively minor skin irritations do not generally indicate a need for skilled care.

Dressing:—Special services in connection with the application of dressings involving prescription medications and aseptic techniques constitute skilled services. Routine changes of dressings, particularly in non-infected post-operative or chronic conditions, generally do not require skilled services or supervision.

Plaster casts:—Special care for patients who have casts over any part of the body should be indicated in the physician's orders. Ordinarily, however, the presence of a cast does not necessarily establish a need for skilled services.

This is the second in a series of articles devoted to the discussion of the care your patient can receive in a facility participating in the Medicare program.

Examples of other covered services will be outlined in the next issue.

The patient who has had a myocardial infarction is usually advised by his physician to avoid emotional excitement. All too often his family, acutely concerned, transmits its anxiety to him, urging him to "rest, rest."

How anxiety may interfere

In a study of 336 males who had suffered at least one myocardial infarction, Sigler¹ reports that manual workers showed the lowest percentage of patients returning to work, compared to clerical workers, business and professional men. The author notes that in many cases the mere apprehension that "return to work would shorten life prevents the patient from resuming activities." It is also well known that emotional disturbance is probably the most common cause of cardiac disability in postinfarction cases.¹

The anxiety factor in both *coronary* and *precoronary* patients has recently been discussed by Thomas,² who suggests: "Intensive investigation of the sources and kinds of anxiety, and how destructive forms of anxiety can be identified and relieved may be the next important step in the prevention of coronary heart disease."

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References: 1. Sigler, L. H.: *Geriatrics*, 22:(9) 97, 1967. 2. Thomas, C. B.: *Johns Hopkins Med. J.*, 122:69, 1968.

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Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating

drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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New Officers of ISMS Elected

This month's cover combines the old with the new—antique frames with the new ISMS officers elected at the 130th annual meeting in Chicago, May 17-20.

Dr. J. Ernest Breed assumes the presidency of the 10,500-member society, after completing a year as president-elect.

An active participant in ISMS activities, Dr. Breed has been a delegate for ten years, trustee for nine years and a member of the Publications Committee and Ethical Relations Committee. He has also served in the capacity of consultant to the Committees on Legislation, Cancer, Medicine and Religion, Radiology and Public Affairs.

Dr. Breed is also a member of various radiology and nuclear medicine societies and has served as a consultant to the AMA Committee on Religion and Medicine in the preparation of its manual for physicians.

Presently an associate in radiology at Northwestern, Dr. Breed's practice focuses on radium therapy. He is on the staffs of Augustana Hospital and Swedish Covenant Hospital. Dr. Breed is also known as the deviser of the "pneumatron," an instrument which permits high-intensity therapy of accessible tumors at short distances.

Dr. L. T. Fruin, Normal, was named president-elect of ISMS. A member of the society since 1935, Dr. Fruin has served as vice-president and as a member of several committees. He is currently co-chairman of the Committee on Credentials.

Dr. Fruin brings valuable experience to ISMS after serving as president of his hospital medical staff, president of the McLean County Medical Society, and president of the Central Illinois Medical Association. He is the founder of Fruin Clinic in Normal, and presently serves as the director.

Dr. Jacob E. Reisch, Springfield, begins his tenth year as secretary-treasurer of the society.

Dr. Reisch has served the ISMS Executive and Finance Committees since 1960, and been vice-president, an ISMS delegate to the AMA, and served on the Board of Trustees. Currently he heads an ISMS committee on Physicians Liability Evaluations. He has also served as chairman of other committees, including the Publications Com-

mittee, responsible for the **Illinois Medical Journal**.

Since 1956, Dr. Reisch has served on the Governor's Advisory Board of Necropsy Service, and is a member of the Medical School Planning Committee for the Southern Illinois University Medical School now being established in Springfield.

Dr. Paul W. Sunderland, Gibson City, was named speaker of the House of Delegates in action taken by that 210 member policy-making body.

For the past three years, Dr. Sunderland has served as vice-speaker of the House and as a consultant to the Council on Public Relations and Membership Services.

A general practitioner and staff member of the Gibson City Community Hospital, Dr. Sunderland is also affiliated with the AMA and the American Academy of General Practice.

Dr. Willard C. Scrivner, East St. Louis, was elected chairman of the Board of Trustees at the post-convention Board meeting.

An obstetrician and gynecologist, Dr. Scrivner has functioned as a consultant to the ISMS Nursing Committee and Maternal Welfare Committee, as well as a member of the AMA's Committee on Health Care of the Poor.

Dr. Scrivner is also past president of the Southern Illinois Medical Society, the St. Clair County Medical Society, the Illinois Obstetrical and Gynecological Society and the Illinois and American Associations for Maternal and Child Health.

He is on the staff of seven hospitals in St. Louis (Mo.), East St. Louis and Belleville (Ill.). Dr. Scrivner is also assistant clinical professor in the Department of Obstetrics and Gynecology, Washington University Medical School, St. Louis.

A Diplomate of the American Board of Obstetrics and Gynecology, and a Fellow of the American College of Surgeons, Dr. Scrivner is also active in nursing education in the Belleville area.

Convention highlights, Abstracts of Board Actions, and other newsworthy events which took place at the 130th annual meeting will be featured in the July issue of the Illinois Medical Journal.

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Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety,

and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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J. Ernest Breed

The President's Page

Inaugural Address

Mr. Speaker, Doctor Cannady, fellow officers, members of the House of Delegates and guests. It is indeed a difficult assignment to follow Doctor Edward Cannady as your President. I assure you, however, that I will do my best to discharge the responsibilities I have assumed and to try to justify the high honor you have conferred upon me.

The President's Inaugural Address should outline the major projects to be pursued by the Society in the coming year. Since such projects are of great significance not only to the membership, but to the public as a whole, it is essential that leaders of the Society endorse the projects to be embraced. I therefore present several for your consideration.

Today I will discuss four major areas upon which I plan to place emphasis in the next year. They are Continuing Education, Peer Review, Malpractice, and Changes In The Delivery of Health Care. To me these seem most important and I hope that you will agree.

Peer Review . . . Malpractice . . . Continuing Education

I pledge to work for our new program of peer review—and for liaison with the county societies in this endeavor. For peer review is our way of confronting the complexities of private and third-party coverage—at a time when half the costs of medical care are transacted by insurers or government. It is our voluntary, self-directed way of showing we can meet the economic challenges of medicine. It is our way of assessing the quality of care, and ensuring that the charge is reasonable, usual and customary.

I pledge to help fight the growing intimidation of fraudulent malpractice claims.

More and more patients, in this acquisitive age, seem to think that suits against doctors are a good financial bet; so do many lawyers.

The most insidious effect of the malpractice suit epidemic is on our daily practice. Many doctors are shying away from new techniques, surgery and drugs. They are, to use the vernacular, "running scared." To be on the safe side, they order extra lab tests and X-rays; they hospitalize the patient longer than necessary. And they worry, of course, about adequate insurance protection. Thus the greed of some patients—and lawyers—is running up the costs and retarding medical progress for all patients. The rash of bogus claims must be arrested! ISMS is examining the feasibility of forming a committee of physicians who, upon request, would screen threatened suits. If the member appears liable, he would be advised to settle; if he appears blameless, he would be furnished expert testimony for his defense.

I pledge to support the furtherance of continuing education, and cooperate with other groups toward this end. Doctor Cannady worked devotedly for the creation of an independent Council on Continuing Medical Education, allying the efforts of ISMS, other professional bodies and the medical schools. The plan must be brought to fruition. Unless full-scale continuing education is achieved voluntarily, the federal government, the state licensing board—and the public itself—may insist it be compulsory.

Impatient and insinuating fingers are pointed at us by political aspirants, socialists and others. Even our own Federal Government makes threatening gestures. Pick up your daily newspaper, and you read about the medical impoverishment of the

(Continued on page 639)

Intermittent Jaundice:

The result of a prolapsed gastric tumor occluding the common bile duct

BY GEORGE J. RUKSTINAT, M.D., FRANK J. SALETTA, M.D., and
CASIMIR W. TULEJA, M.D./CHICAGO

The patient, a retired man 82-years-old was admitted to Holy Cross Hospital for cataract extraction. The ophthalmologist refused to operate because the patient was jaundiced, so additional diagnostic procedures were performed. The patient had had a cholecystectomy 30 years previously, and only recently developed intermittent jaundice which now was continuous. A biopsy of the liver showed severe cholestasis with foci of necrosis. A liver scan was

normal. The cephalin flocculation test was negative. X-ray studies of the upper gastro-intestinal tract were not revealing. Blood chemistry determinations showed only minimal departures from the normal. The blood urea nitrogen was 22 (normal 10-20); glucose was 130 (normal 60-110); albumin was 2.7 (normal 3.5-5); the total bilirubin was 1.7 (normal 0.1-1.0); the alkaline phosphatase showed considerable elevation 180 (40-70); the SGOT was 80 (20-50); and the



George J. Rukstinat, M.D. (right), is Director of Laboratories, Holy Cross Hospital and clinical professor of pathology at Stritch School of Medicine, Loyola University. He is also a Fellow of the American Board of Pathologists. Frank J. Saletta, M.D. (left), is Chairman of Surgery at Holy Cross Hospital and a Fellow of the American College of Surgeons.



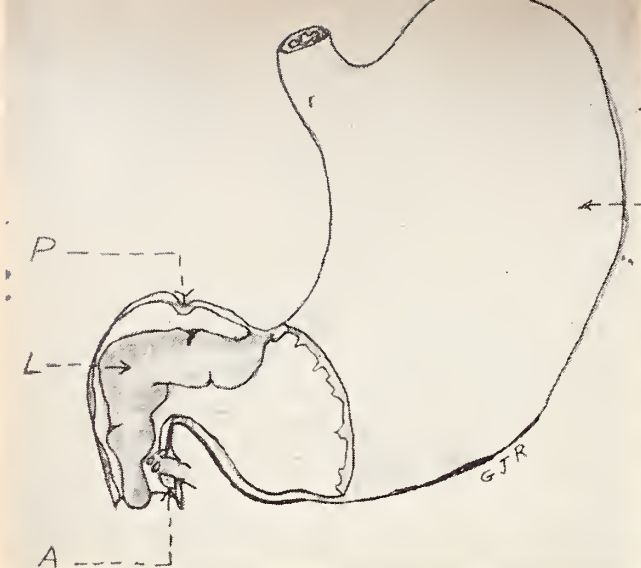


Fig. 1. Illustrating at: G—the gastric fundus; P—the pylorus; L—the antral lipoma, attached to the lesser curvature and prolapsed into the duodenum; A—the ampulla of Vater where the mouth of the common bile duct was occluded by tumor pressure.

A/G ratio was 0.85/1.0. The electrocardiogram was normal.

The patient had only a fair appetite, had lost eight pounds in the preceding three weeks and had occasional diarrhea. Because of an irregular fever, further tests were run on the genito-urinary system. A partial bladder outlet obstruction was found with a slightly enlarged prostate gland. *E. coli* was found in abundance in the urine. There was a diverticulosis of the urinary bladder. The sedimentation rate was increased.

It was decided to treat the patient conservatively for 2 to 3 weeks and then re-examine him. Due to recurrence of the fever and jaundice, the patient was readmitted two months later with advice to have an exploratory operation for possible common duct stone or carcinoma of the head of the pancreas. The operative procedure consisted of excision of the old operative scar and extensive enterolysis. The common bile duct was opened and drained of muco-purulent content but no stone was found. When the duodenum was opened a pedunculated intussuscepted gastric "polyp" was removed and the base sutured. Pressure by this "polyp" on the mouth of the common bile duct was the cause of biliary retention and jaundice. Due to the pressure on the sphincter of Oddi there appeared to be a sclerosing at this site; therefore, rather than a sphincterotomy a choledocho-duodenostomy was performed. A Penrose drain was inserted through a right lateral stab wound and the abdomen closed.

The pathological examination of the poly-

poid mass showed it to be 4.1 cm. long and 3.2 cm. in greatest diameter. The covering resembled gastric mucosa, while the interior was lobulated and yellow. Histologically the epithelial covering was supplied with gastric glands and between these were occasional hemorrhages. The yellow bulk of the mass was composed of mature fat cells, occasionally separated by thin strands of connective tissue.

Discussion

The cause of jaundice is sometimes elusive and this is especially true of the intermittent type. Liver biopsy and an elevated L.D.H. were compatible with a tentative diagnosis of low grade infection with a stone in the common duct in the present case. The sedimentation rate and fever also fit this picture. The exploratory quickly solved the problem with the finding of the prolapsed gastric polypoid lipoma detailed above. The gastric mucosal covering did not participate in the tumor growth.

Considerations of gastric polypoid structures are mainly concerned with cancerous changes in the epithelium. Thus, studies by Priestly, et al.¹ on 465 patients with gastric polyps resulted in a division into three groups. The first group consisted of 165 patients in whom a clinical diagnosis was made but who were not operated upon. The second group included 206 in whom, at operation, an adenomatous polyp or polyps were found. Subdivision of this group included 181 patients who had benign adenomatous polyps with grade 1 or 2 (Broders) at the tip without invasion of the stalk. The third group had a variety of lesions other than adenomatous polyps such as polypoid adenocarcinoma, malignant lesions of various types and occasional benign gastric lesions. Cancer of the stomach was also found associated with gastric polyps.

The experience of numerous investigators and surgeons is attested by numerous and varied publications. Monaco² and his co-workers recorded their experiences with 153 adenomatous polyps of the stomach. Hay³ reported on the surgical management of 69 patients with benign gastric adenomas. Multiplicity of gastric polyps has repeatedly received attention. In 1926 Brunn and Pearl⁴ reported diffuse gastric polyposis, (adenopapillomatosis gastrica) in 5 patients. They also reported on 84 patients each of whom had three or more polyps.

With the development of newer radiographic methods, the use of the gastroscope and employment of the gastric camera, polyps of the stomach should be more readily diagnosed. Fortuitous discovery of such tumors has also been recorded. Crone⁵ in 1857, had a young female patient who had repeated attacks of vomiting. Her symptoms finally ended when she vomited a piece of tissue which proved to be an adenoma.

Summary

1. A case is reported of a patient with intermittent jaundice, fever, and weight loss of several months duration.
2. The symptoms were entirely relieved by resection of a polypoid lipoma of the antrum which had prolapsed into the duodenum obstructing the mouth of the common bile duct. ◀

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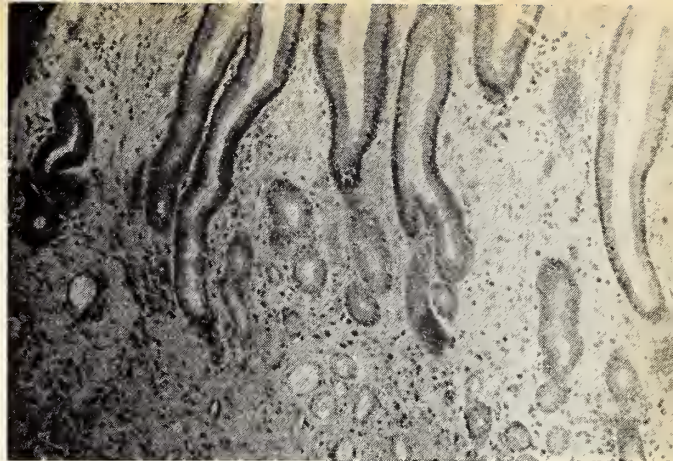


Fig. 2. Illustrating the well-defined gastric glandular covering of the tumor and the underlying edematous lipoma.

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5. Welch, E. C., "Polypoid Lesions of the Stomach in Gastrointestinal Tract Vol. II." *MAJOR PROBLEMS IN CLINICAL SURGERY*, W. B. Saunders, Phila., and London, 1967, p. 132.

Clinics for Crippled Children Scheduled

Twenty-two clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The Division will hold 18 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with the medical, social, and nursing services. There will be three special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- July 1—Hinsdale—Hinsdale Sanitarium
- July 8—Champaign-Urbana—McKinley Hospital
- July 8—Joliet—St. Joseph's Hospital
- July 9—Sterling—Community General Hospital
- July 9—Flora—Clay County Hospital
- July 9—Springfield General—St. John's Hospital

- July 9—Cairo—Public Health Department
- July 9—Macomb—McDonough District Hospital
- July 10—Chicago Heights Cardiac—St. James Hospital
- July 14—Peoria—St. Francis Children's Hospital
- July 14—East St. Louis—Christian Welfare Hospital
- July 14—Quincy—Blessing Hospital
- July 16—Decatur—Decatur Memorial Hospital
- July 16—Elmhurst Cardiac—Memorial Hospital of DuPage County
- July 21—Rock Island Area General—Moline Public Hospital
- July 22—Mt. Vernon—Good Samaritan Hospital
- July 22—Rockford—St. Anthony Hospital
- July 22—Centralia—St. Mary's Hospital
- July 22—Elgin—Sherman Hospital
- July 24—Chicago Heights Cardiac — St. James Hospital
- July 28—Peoria—St. Francis Children's Hospital
- July 29—Springfield Pediatric Neurology—Diocesan Center

Therapy for AHF and PTC Hemophilia

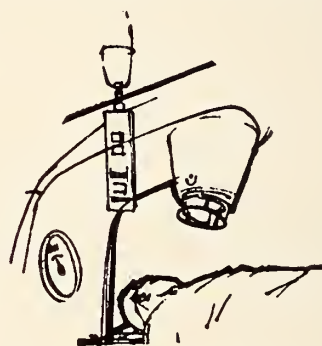
BY RUTH A. SEELER, M.D./CHICAGO

Part II of a two-part article

Commercial Preparations

There are two lyophilized AHF preparations available which are equally effective and convenient. Both are prepared from selective donor pools, thus, hepatitis has been an infrequent problem. Each lot is assayed and labeled as to the number of units of AHF. This means that when reconstituted the bottle is equivalent to that number of cc's of fresh pooled plasma of 100% AHF activity. Both products are relatively low in plasma proteins, of similar a volume (25-30 cc) when reconstituted and contain similar numbers (170-250) units of AHF. Normal isohemagglutins are present in both and the fibrinogen content is similar. The products are dated and stable when stored in blood bank refrigerators. Each is packaged with diluent, filter and tubing for administration. When reconstituted the concentrate should be infused without delay. It is important to infuse all the material, thus administration tubing should be flushed with saline. When more than one bottle is to be given they may be combined. The material can be given

Medical Progress



HARVEY KRAVITZ, M.D.
Medical Progress Editor

via plastic syringe provided it is filtered first (see cryoprecipitate section). A word of caution, when reconstituting the concentrates the bottles should be swirled, not shaken. Foam formation is equivalent to AHF destruction. Also, warming the di-



Ruth Andrea Seeler, M.D., is a pediatric hematologist at Cook County Hospital, and assistant professor of pediatrics at the University of Illinois. She is also from the Division of Pediatrics, Department of Hematology, Hektoen Institute; and received her M.D. from the University of Vermont.

luent to 37°C but not higher, greatly facilitates solubilization of the material.

The products referred to are Courtland Laboratories—Antihemophiliac Factor® and Hyland—AHF (Human)®. The former is lyophilized pooled cryoprecipitate, the latter is a lyophilized glycine precipitate.²¹ Hyland Method IV which contains 125 units of AHF in 4-5 cc is not generally available at this writing.³⁰ If it becomes available it will be significant further purification of AHF.

Commercial Concentrates Versus Cryoprecipitates

Properly prepared cryoprecipitate is as effective as the commercial products and much cheaper. The primary disadvantage is its variable potency.^{26,29} No problem exists when AHF levels are determined after infusions. In surgical problems it is our policy to use cryoprecipitate during the day and assay the patient. Should the desired level not be obtained another infusion is given. For evening infusions the commercial products of known potency are used. The infusion of cryoprecipitate from one unit of blood per 6 kg of body weight has regularly resulted in the achievement of therapeutic levels.^{25,29}

The hepatitis risk cannot be stated in absolute terms. When the cryoprecipitate is prepared from a donor or select group of donors by regular plasmaphoresis the risk is minimal. The donors used by the commercial companies have been carefully chosen and hepatitis is very infrequent. The risk is totally unknown for the use of cryoprecipitate prepared from routine blood donors and will vary with the individual blood banks. The routine screening of donors for the Hepatitis Associated Antigen (HAA) may at last provide a way for minimizing or eliminating this hazard of transfusions.³¹

PTC Concentrates

There are two types of PTC concentrates, but only one is currently available, Konyne®, by Cutter Laboratories.³²⁻³⁴ The long delay in preparing a PTC concentrate was due to technical problems related to prothrombin activation. Because the Vitamin K dependent coagulation factors have many common physical chemical properties, prothrombin, Stuart-Prower and Stable

factor are obtained with PTC. Prothrombin is very easily activated during the separation procedures to thrombin, a very dangerous substance if infused intravenously.

The infusion of 1 unit of PTC per kg of body weight produces a rise of 1% in the patient.³² This may be due to wider distribution of PTC or to activation of PTC in the preparation of the concentrates. The activated PTC would immediately be removed after infusion and thus not measurable. A bottle of Konyne® when reconstituted with 20 cc of provided diluent is equivalent to 500 cc fresh pooled plasma. Like the AHF concentrates, it is assayed, lyophilized, dated, stable at 4° and comes with diluent, filter and tubing for administration.

How Much—How Often

In order to effectively plan the intensity of replacement therapy, the location of bleeding, intactness of skin or mucus membranes, and history of trauma or associated illness are of paramount importance. A large traumatic hematoma of the quadriceps may require less therapy than a small laryngeal hematoma associated with a sore throat or pertussis. The following general outline is offered as a basis for planning the therapy of an individual bleeding episode.

For simplicity I shall refer only to AHF. In PTC deficient patients the number of units per/kg will have to be doubled to achieve a desired therapeutic level.³² Cryoprecipitate has no PTC and is not used.

Hemarthrosis and Intramuscular Hematomas

Hemorrhage, spontaneous or following minor trauma, commonly involves the knees, ankles, elbow joints and gastrocnemius, quadriceps, or iliopsoas muscles. Although the infusion of 10-15 units per kg or 1 unit of cryoprecipitate per 6-8 kg is sometimes sufficient, a similar dose 12 hours later is usually required.¹ Hemorrhage resulting from trauma requires therapy for several days. Alternatively, a single infusion of 20-30 units of AHF per kg is satisfactory in many cases.³⁷

Infusions are repeated until the involved area is less tender. Local measures are an adjunct to, not a substitute for, correction of the coagulation defect. The involved area should be rested in the position of

function. Ice packs may be helpful, but many patients find them very uncomfortable, and I do not insist they be used.

Whether joint aspirations should be performed routinely for hemarthrosis is unsettled.^{8,35} In experienced hands this is believed to decrease the incidence of crippling joint deformity.³⁶ It must be emphasized that aspirations are done only after replacement therapy is given and by those once experienced with the procedure.^{1,35} Because of the lack of convincing controlled studies³⁵ it is not our practice to routinely aspirate hemarthrosis.

When the pain and swelling improve, the patient should be encouraged to start active exercises in order to regain a full range of motion as soon as possible. A whirlpool is very helpful in rehabilitation after bleeding episodes involving the lower extremities.

Oral Lesions

Small lacerations of the mucous membrane surfaces of the oral cavity can be among the most difficult lesions to treat. Lacerations of the frenulum and gums commonly occur in small children from falls while they are learning to walk. The clots, bathed in saliva and disturbed by sucking or eating, are repeatedly dislodged. Therefore, it is necessary to maintain hemostatic levels of the coagulation factor until the wound is healed. Treating PRN for bleeding won't work. These patients are placed on intravenous feedings, and given 15-20 units of AHF per kg every 12 hours until epithelization has occurred, which usually takes 2-3 days. Alternately an infusion of 40-60 units per kg can be given every 24 hours.^{25,37}

Because saliva contains fibrinolytic activity, Epsilon Amino Caproic Acid (Amicar®) may be given, in the dose of 100 mg per kg per dose every 6 hours to block activation of the fibrinolysin. The drug is very rapidly excreted in the urine and to be effective must be given q 6 hours, not q.i.d.³⁸⁻⁴⁰

Dental Extractions

It is far easier and safer to have regular dental care with filling of caries while they are small than to manage the potential hemorrhagic situation that accompanies an extraction. Dental surgery requires the ut-

most co-operation of an oral surgeon and hematologist. Attention to the details of anesthesia, socket packing with absorbable material soaked in topical thrombin, and preparation of a dental splint to protect the extraction socket are mandatory.³⁸⁻⁴⁰

EACA is started 24 hours preoperatively and continued q 6 hours until the wound is healed. Regular infusions of the coagulation factor are maintained for a similar time. The patients may be maintained on a liquid diet and do not have to be NPO. Sedation is helpful in aiding the patient to tolerate the dental splint. He must be warned not to let his tongue move the splint thus dislodging the clot. Should this happen, it is necessary to repack the socket. Suturing of the socket is avoided because it is better to see the blood in the mouth than to have it dissect into the pharynx and obstruct the airway.⁴⁶

Abdominal Pain

Hemophiliacs with severe abdominal pain may have a "surgical" abdomen, or retroperitoneal hematoma. Bleeding into the iliopsoas muscle may present the findings of acute appendicitis. Such patients are given an infusion of 25-30 units of AHF/kg, or 1 unit of cryoprecipitate per 4-5 kg and observed for 12-18 hours. Such doses insure hemostatic levels for the period of observation and if the problem was bleeding the patient will have improved. An intravenous pyelogram is helpful in detecting a retroperitoneal hematoma because the ureters are displaced anteriorly.

Surgery

Before any surgical procedure is undertaken it is mandatory to test for the presence of an anticoagulant.²⁰ Additionally, one must be sure that sufficient coagulation factor replacement is available to maintain hemostatic levels for at least 10 days following operation. Although the minimal level of necessary and present surgical hemorrhage coagulation factor has not been concretely established, many hematologists suggest that 20-30% must be maintained at all times until the wound is healed.^{1-5,26-29,41} It is better to err on the side of overtreatment than undertreatment, but one does not want to waste the material. A level of 80-100% at the time of surgery allows for unanticipated delays, and provides reassurance. We determine

the AHF level after each infusion of cryoprecipitate, or use one of the commercial products. For initial therapy 40-50 units of AHF per kg or 1 unit of cryoprecipitate per 3-4 kg are given. Every 12 hours thereafter one half the above dose is infused.

With this therapy we have successfully evacuated two subdural hematomas in patients with severe AHF deficiency. Similar therapy has been successfully used by others in patients undergoing orthopedic,^{28,41,45} neurosurgical,⁴²⁻⁴⁴ and abnormal operations.^{27-29,44}

Lacerations

Hemophiliacs with lacerations should be treated as outlined for surgical conditions. Suturing a laceration and applying a pressure dressing, frequently results in the blood dissecting through the fascial planes. We transfuse the needed coagulation factor and then clean and debrided the wound. Surface adhesive strips are used to close the skin, thus avoiding the potential for hemorrhage associated with suture removal. Because most lacerations are on the extremities, it is important to prevent wound stress by splinting, to prevent motion. Circumferential casts should not be applied because if hemorrhage continues the swelling may result in severe skin compression and sloughing, requiring skin grafting.

Fractures

Fractures are treated as outlined under surgery. If possible, traction should be used initially to maintain the position. Casting may be used once the swelling begins receding, at which time replacement therapy is discontinued.

Prophylaxis

When caring for a hemophiliac it is necessary to be prepared to treat emergencies at all times. This necessitates keeping an adequate supply of PTC and AHF concentrates on hand. Emergencies have a way of happening over long holiday weekends.

It is far better to prevent bleeding than to treat it. The necessity for regular dental care is obvious and has been discussed. Routine immunizations of children for diphtheria, tetanus, pertussis and measles should be given. If one uses a 25 gauge needle the only problem is a small hematoma at the injection site. Pertussis in a

hemophiliac can be a life-threatening disease because coughing and whooping can lead to laryngeal hemorrhage and death. We have treated an unimmunized hemophiliac with this complication. Replacement therapy was needed until the cough disappeared. In some children the paroxysms occur for weeks.

A sore throat or croup may lead to laryngeal, or retropharyngeal hemorrhages which seriously compromise the airway.⁴⁶ It is important to warn patients about this possibility so that they seek medical advice when any change occurs in their voice. Therapy is as for surgery.

In treating a streptococcal sore throat one should not give intramuscular penicillin. It is very irritating and may cause a large hematoma necessitating replacement therapy. Recently a three-year-old known hemophiliac was treated elsewhere for pneumonia with intra-muscular penicillin. In two days the child's thighs were intensely swollen and the hematocrit had fallen from 33 to 22%. One third of this child's red cell mass was within these hematomas. In adults 500-1000 cc's of blood may be lost into the muscle mass of the thighs and buttocks.

Other deep irritating, intramuscular preparations such as the phenothiazine tranquilizers, morphine derivatives and synthetics and antibiotics are equally prone to produce hemorrhage at the injection site. Under such circumstances the absorption and therapeutic effectiveness of the injected drug will be poor.

To date there are no preparations sufficiently concentrated making daily prophylactic injections possible.⁴⁷ Due to the short half-life of AHF, daily infusions are needed^{48,49} and such therapy is undertaken only in exceptional circumstances.

Acknowledgment

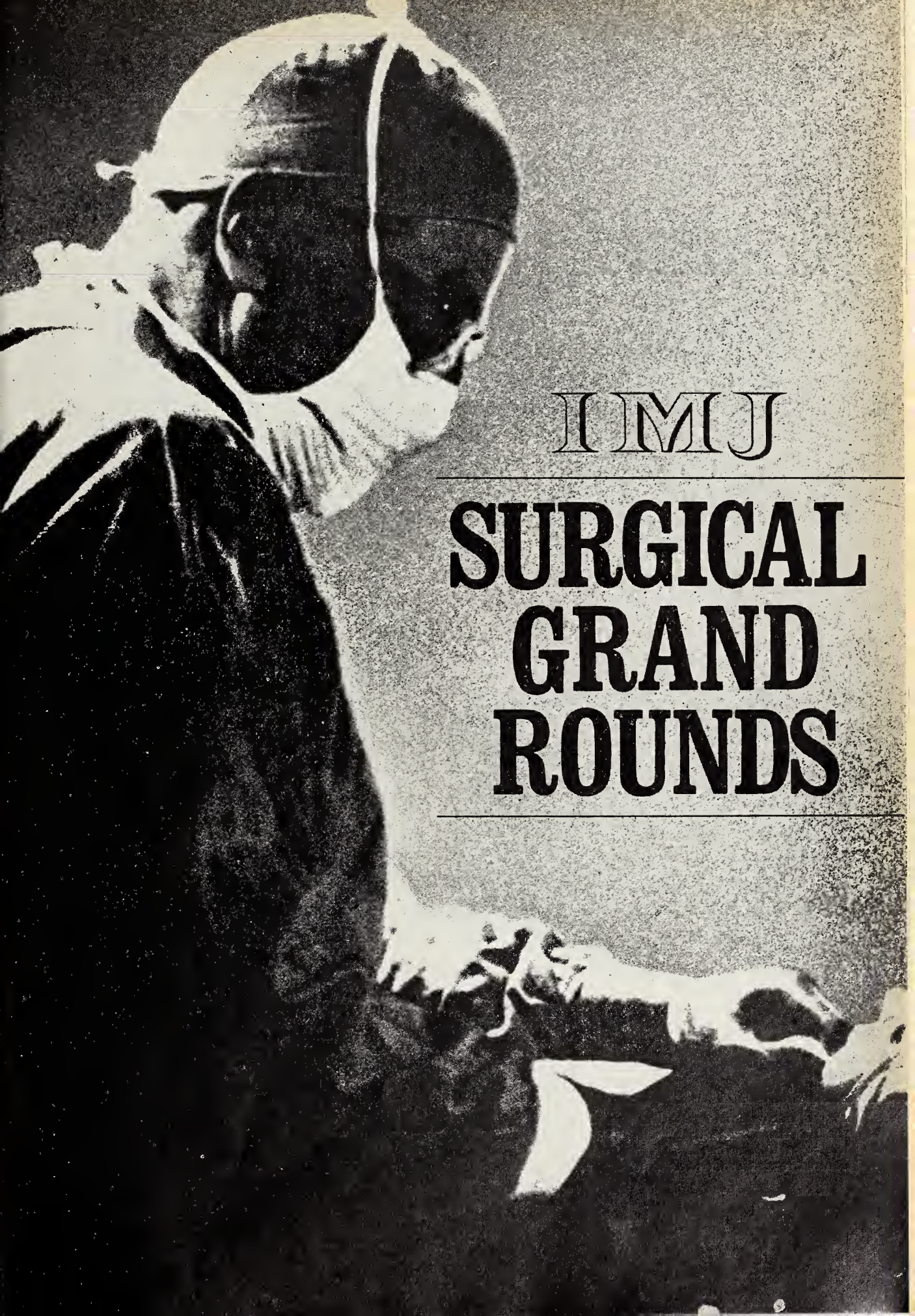
The author wishes to thank Dr. Leo Weiner for critical review of the manuscript. ◀

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(Continued on page 658)



IMJ

**SURGICAL
GRAND
ROUNDS**

Retroperitoneal Mass

Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m., alternating between the Staff Room at Chicago Wesley Memorial Hospital and Offield Auditorium at Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds at Passavant Memorial Hospital on January 10, 1970.

EDITED BY JOHN M. BEAL, M.D.



Fig. 1. Intravenous pyelogram demonstrates deviation of the left ureter. The dense shadow at the upper pole of the right kidney is the gallbladder which is filled with contrast agent from cholecystography.

Case Report:

Dr. A. Barry Belman: A 31-year-old male was admitted to the Psychiatric Service at the Veterans Administration Research Hospital in May, with a diagnosis of acute schizophrenia. After he had been in the hospital, it was noted that the patient was having febrile episodes and a search was begun for the source of his fever. Although he did not have physical complaints, his psychiatric status made his history unreliable. When the patient was examined, he was found to be obese and of short stature. Abdominal examination revealed only a massive panniculus. Examination of the genitalia revealed a mass beneath the lower pole of the left testis which was thought to be an indurated epididymis. Urinalysis and blood counts were normal. During evaluation, he had upper and lower gastrointestinal X-rays, which were negative, and then an intravenous pyelogram.

Dr. Stanley Hoover: Intravenous pyelogram shows prompt excretion bilaterally without intrinsic genitourinary abnormality. There is lateral deviation of the left ureter, approximately 2 to 3 cm. (Fig. 1) from its usual position, at the level of L-3 and L-4. The ureter is neither narrowed nor obstructed. The displacement of the ureter is

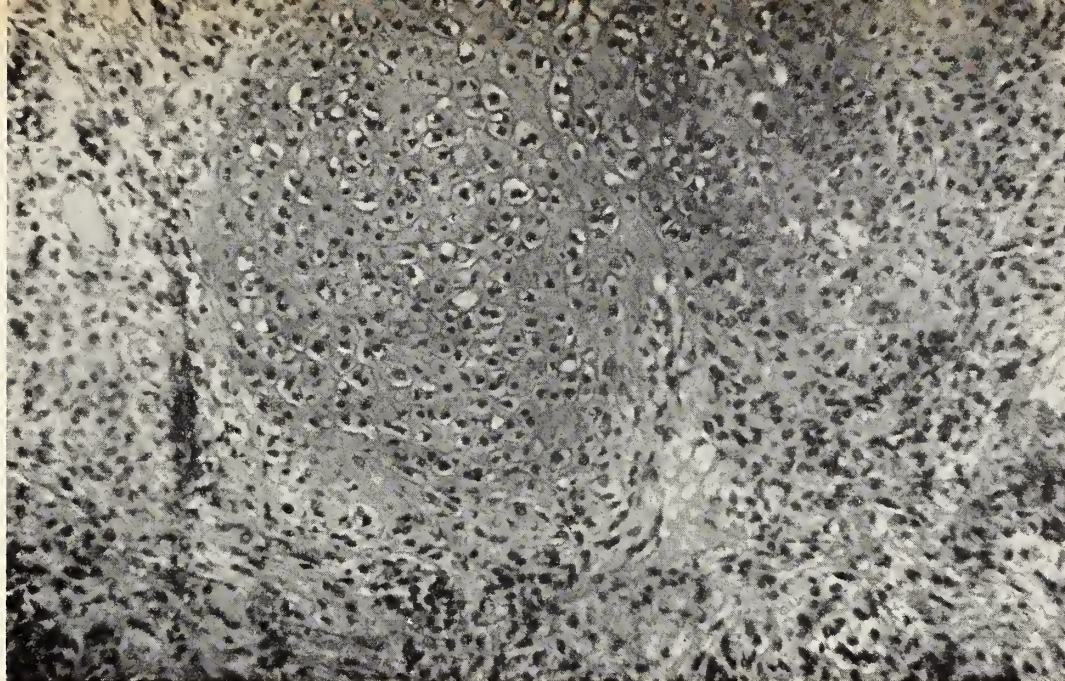


Fig. 2. Photomicrograph of retroperitoneal tumor, showing immature cartilage.

typical of a medial retroperitoneal mass, most likely enlarged lymph nodes.

Dr. Belman: Because of this finding, an operation was performed. Using a lateral decubitus position, the mass was approached through a transverse subcostal incision, exposing the retroperitoneal area. The ureter was pushed anteriolaterally by a large underlying mass. Because of the tremendous amount of fat involved, dissection was difficult. A solitary encysted mass was removed which was adjacent to but not communicating with the aorta. It extended toward the renal hilum but was not attached to the kidney. The mass was removed by enucleation. There was a second, "daughter-type," smaller mass that was removed at the same time.

Dr. Joseph C. Sherrick: Sections through this large retroperitoneal mass showed a tumor with a variegated appearance. The tumor was composed of many different types of tissue, including loosely arranged embryonic connective tissue, immature cartilage (Fig. 2), a great deal of glandular tissue of various types (Fig. 3), and a few cysts lined by squamous epithelium. There were even some areas resembling nervous tissue. It was not possible to say that the large mass represented lymph node replaced by tumor, but in one of the retroperitoneal lymph nodes removed, tumor was identified. Our diagnosis was malignant teratoma, and of course in a young male, one should think of a primary tumor in the testis.

Dr. Belman: After the pathology report was received, the left testis was examined again

and the mass at the lower pole was still considered to be chronic epididymitis. However, it was more closely attached to the testis than would be expected. Exploration of the scrotum was required to determine the precise nature of this mass. Two weeks later, this was carried out through an inguinal approach. The left testis was exposed and the mass was found to be within the tunica albuginea, and occupied approximately one-fourth of the testis. The epididymis was normal.

Dr. Sherrick: Sections of the mass in the testis showed it to consist largely of dense hyalinized tissue. A few cysts, partly lined by squamous or columnar epithelium, were noted. Other parts of the tumor consisted of large cells which are arranged in a tubular or glandular manner in some areas and suggest seminoma or embryonal carcinoma (Fig. 4).

The pathological diagnosis on this case is malignant teratoma of testis with metastasis to retroperitoneal region. The prognosis is poor, since about 70% of these patients are dead within two years.

Dr. Belman: Under usual circumstances, in a patient with malignant teratoma metastatic to the retroperitoneal nodes, we would proceed with a retroperitoneal node dissection. However, because of this man's marked obesity, such a procedure was thought to be contraindicated. Therefore, he was referred to the radiotherapist for treatment.

The patient with a scrotal mass deserves thorough evaluation. It is important to

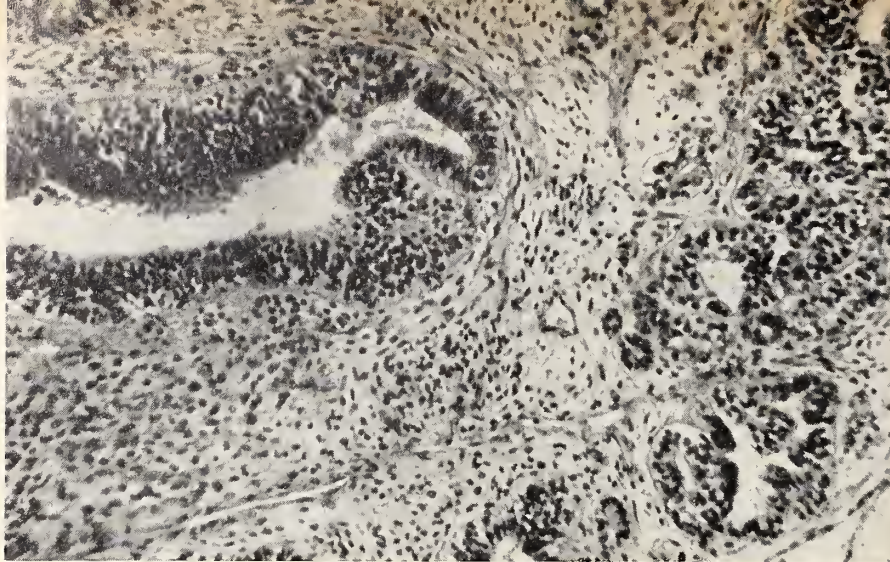


Fig. 3. Photomicrograph of retroperitoneal tumor, showing immature connective tissue and glandular tissue.

determine the acuteness of onset which usually can be done with accuracy. The lesions which occur acutely are most commonly of three different types: the inflammatory lesion, such as epididymitis or orchitis; torsion of the testis; and traumatic lesions. Epididymitis is caused most commonly by a gram negative infection. The patients can frequently give a history of prior urinary tract infection such as prostatitis, chronic urinary tract infection associated with stricture or previous manipulation or urethral instrumentation and fever. The pain is scrotal in location. Examination of the urine discloses pus cells. The pain may be relieved by elevation of the scrotum and early in the course the tender epididymis can be palpated separately from the testis. The testis feels relatively normal, but the epididymis is a large tender, indurated mass at the early stage. Later, the lesion becomes epididymo-orchitis, and a large mass develops so that it may be difficult to separate the epididymis from the testis. Secondary skin changes may occur with adherence of the scrotal skin to the mass giving an "orange peel" effect.

Torsion characteristically is acute in onset, although it may occur insidiously. These patients may awaken with pain. However, the pain in torsion may be abdominal. We saw an 11-year-old boy at Wesley last year who came into the emergency room, complaining of abdominal pain. He was being evaluated for an abdominal catastrophe. When examination of the scrotum was finally carried out a scrotal mass was noted. Surgical exploration revealed an acute testicular torsion. History

of infection or instrumentation is usually absent. They may have intermittent twisting in the past causing similar symptoms which spontaneously abated.

There are two types of torsion—intravaginal and extravaginal. Intravaginal is thought to be due to a long attachment of the tunica vaginalis to the testis and the testis twists within this tunica. Extravaginal torsion may be due to an absent gubernaculum testis so that the entire scrotal content will twist on the cord. On examination, because of the twist, the testis rides higher in the scrotum than normal and, again the contralateral side may have a more horizontal position. Elevation does not give relief in this; it is already elevated.

Treatment of epididymitis is bed rest, elevation, cold compresses and antibiotics. Because there is usually associated urinary

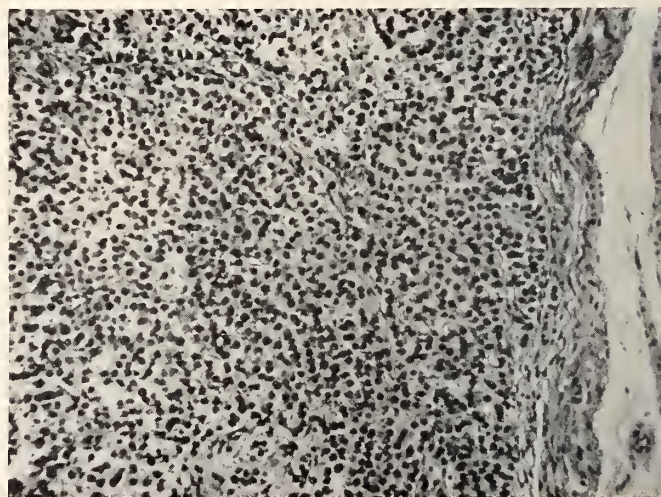


Fig. 4. Photomicrograph of testicular tumor, showing the portion that resembles seminoma.

tract infection, investigation of the urinary tract is indicated. Treatment of torsion, if seen within 12 hours, should be surgical exploration. A scrotal approach is used if the diagnosis is definite. If torsion is present, the testis is untwisted, and then fixed to the scrotal wall. The contralateral side is also fixed, because this is a congenital anomaly with a high risk to the other testis.

Dr. John Grayhack: The most important scrotal masses, of course, are tumors of germinal origin. The classification of testicular tumors is broken up into five groups: the pure seminoma; the embryonal cell carcinoma (these two are the most common); the teratoma, which is relatively rare; the teratocarcinoma, which this patient had; and choriocarcinoma. Choriocarcinoma in the male behaves differently than in the female. In the male, survival rates, even with chemotherapy, are poor. Embryonal cell carcinoma and teratocarcinoma have similar survival rates. Seminoma is treated primarily by orchiectomy with subsequent radiotherapy to the retroperitoneal space. Embryonal cell and teratocarcinoma are usually treated by orchiectomy and retroperitoneal node dissection, because spread is usually by lymphatics. The lymphatics follow the arterial supply and spread first to the area of the renal hilum on the side of the tumor. A third of testicular tumors occur between the ages of 20 and 30, and almost two-thirds occur between the ages of 20 to 40. The incidence is about two in every 100,000 males, although it has been observed recently that testicular tumors are rare in Negroes. One per cent of all tumors in males are testicular. Tumors are more common in the undescended testis, even after orchidopexy.

Scrotal masses should be approached by the inguinal route. The cord is secured in a manner similar to that for hernia repair. Either a rubber-shod clamp or a tight penrose drain is applied to the cord to occlude the venous return. The testis is brought up into the field after the venous return is occluded. After isolating the field, the tunica vaginalis may be opened to determine whether the mass palpated is indeed in the testis. If it is in the testis, remove the testis by transecting the cord above the area previously clamped. Then the cord is dissected as high as possible. Node dissection may be carried out later. We like to be able to remove the remaining cord.

In some centers, radiotherapy is used in the treatment of embryonal cell carcinoma. Statistics from the Navy using combined preoperative and postoperative radiation in association with node dissection in a relatively small group of patients with embryonal cell carcinoma have yielded approximately an 80% five year survival rate. In New York, Dr. Whitmore has used chemotherapy, a form of therapy that we have employed for embryonal cell carcinoma. The patients are treated with Actinomycin-D therapy shortly after node dissection. At two to four week intervals, they receive between a 1½ mg.-1 mg. daily for a five day course. Frequent blood counts are required. Gastrointestinal symptoms of toxicity may occur. The plan of therapy is designed for two years of treatment. At present the results appear to be favorable, but it is too early to draw specific conclusions.

Dr. Leander Riba: Early diagnosis is important for survival. Examination of the scrotum by physicians is usually superficial and should be done with greater care, particularly in the 20 to 40 year age group.

Dr. William Moss: As Dr. Belman implied, the spectrum of radio sensitivity in testicular neoplasms is striking, being most radio sensitive with the seminoma and least radio sensitive with the teratocarcinoma. The principles of radiotherapy are based on these natural radio sensitivities. The areas which we treat are dictated by the lymph node drainages of the various cell types. One can demonstrate by testicular lymphangiograms that the primary drainage of the testicles is to the lymph nodes at the level of the renal blood vessels. A testicular lymphangiogram is somewhat more difficult than a foot lymphangiogram and it is not frequently performed. Consequently, we depend almost entirely upon the foot lymphangiogram for information concerning the degree of involvement. The lymphangiogram has become, as far as I am concerned, an essential part of the work-up on these patients.

Treatment is directed to the region of primary lymphatic drainage. Caution is taken by using the intravenous pyelogram to locate the kidneys. The port is brought to the edges of the kidneys. Sometimes, if the kidneys are sharply oblique, the ports include the upper poles. The scrotum on the involved side is not treated, since if a

proper orchidectomy has been done, recurrence in the scrotum is most uncommon. If at the time of the surgery or if the pathologist is uncertain concerning invasion of the tunica, then we would include the scrotum in the treated field. Caution is taken to bring the port down to the external canal. The testicle is shielded with a hollowed out lead brick.

The big question in most people's minds is what to do with the patient who has no evidence of metastasis. In seminoma, I think the consensus is the same everywhere. Even in the presence of a negative lymphangiogram, we would proceed to treat the retroperitoneal lymph nodes up to the level of the diaphragm. If there is evidence of retroperitoneal lymph node involvement with the seminoma, we also treat the mediastinum and supraclavicular nodes. In the case of embryonal carcinoma, if there are nodes found on retroperitoneal lymph node dissection, we will also proceed to treat the same volume, straight up to include the supraclavicular lymph nodes. To my knowledge, there is no recorded case of a teratocarcinoma, which has been left behind after surgery, having been cured by radiotherapy. In such cases I think the most we have to offer is palliation. If the disease is known to have been left behind, it will be treated with a fairly high dose but the hope for

cure is almost zero. The shrinkage of the teratocarcinomatous mass will depend usually upon the proportion of that mass which is a radio sensitive element. I think the glandular, the cartilaginous, and some of the sarcomatous elements will shrink very poorly.

Dr. Thomas Shields: I noticed on the slide of Dr. Belman's that there were no five year survivals in the group of patients with choriocarcinoma of the testes. This is in complete contrast to what Dr. Brewer reports in his group of female patients with gestational choriocarcinoma treated with chemotherapy.

Dr. Belman: There is really very little in the literature right now about choriocarcinoma in the male and from what there is, this appears to be a different disease from gestational choriocarcinoma in the female. The combined chemotherapy results are not nearly as good as in the female.

Dr. James Apostol: Choriocarcinoma associated with pregnancy responds to chemotherapy differently than primary ovarian choriocarcinoma and testicular choriocarcinoma. Choriocarcinoma of the ovary not associated with pregnancy behaves more like choriocarcinoma of the testes but there is some difference. Five year survivals after chemotherapy are higher in patients with ovarian choriocarcinoma. ◀

Film Reviews

"Chronic Bronchitis and Pulmonary Emphysema" is a 16mm, color, sound, film-strip in two parts. Part I reviews the physiology and pathology of chronic bronchitis and pulmonary emphysema, and demonstrates equipment and diagnostic techniques used. Part II demonstrates clinical methods effective in enabling the patient to participate in daily activities and occupational demands. The film can be secured on free short-term loan by contacting: National Medical Audiovisual Center (Annex), Station K, Atlanta, Ga. 30324.

Orthopedic surgeons, neurologists and medical students will find "Basis of Diagnosis of Peripheral Nerve Injuries to the Upper Limb," a 35mm, color, sound, film-strip of particular interest. The 22 minute film presents a logical approach to the understanding of peripheral nerve development and demonstrates how this information may be used as a background for clinical analysis. Contact for free short-term loan: National Medical Audiovisual Center (Annex), Station K, Atlanta, Ga. 30324.

And Maybe We'll All Ride On Air

"In the next two decades—by 1990—we will have to duplicate all the transportation facilities we have put in place since the founding of our country."—Secretary John Volpe of the Department of Transportation.



THE DOCTOR'S LIBRARY

OPHTHALMOLOGY PRINCIPLES AND CONCEPTS. (2nd Edition), By Frank W. Newell, M.D., C. V. Mosby Company, St. Louis, 1969, 527 pages, 233 figures, \$15.50.

This book has been written for both medical students and practicing physicians. For the student, emphasis has been on the correlation of clinical ophthalmology with the basic sciences; such an approach facilitates the learning of important concepts which are unlikely to be forgotten. For the practitioner, there is a wealth of straightforward, useful, practical material. The use of instruments usually available only to ophthalmologists has not been stressed; instead, most findings are discussed in terms of what may be observed with the flashlight, ophthalmoscope or other common device.

In an age characterized by an information explosion, the author is to be congratulated for actually decreasing the amount of text in the second edition of this book. The generous use of large tables summarizing the text, and a glossary, facilitates efficient study and quick reference. However, the definitions in the glossary, in an attempt to be brief, may be somewhat misleading. For example, the glossary definition of Brushfield's spots suggest that they occur only in mongolism, an idea which is properly contradicted in the text. The glossary also suggests that retrolental fibroplasia is related to a high concentration of oxygen in the inspired air, while the text gives the more enlightened view that it is the excessively high arterial oxygen concentrations which cause the difficulty.

A large number of illustrations are elegant, simple, black and white diagrams. The quality of the photographic reproductions is quite good with the exception of a few fundus photographs and photomicrographs. Parenthetically, the figure which

demonstrates one interpretation of the organization of the oculomotor and trochlear nuclei is of historical significance since more recent information is available.

The author is an authority in his field and certain chapters such as "Pharmacology" and "Hereditary Disorders" are a joy to read. We wish that the author would have shared more of his knowledge in other areas such as comitant esotropia, but these criticisms are minor.

The book is well organized, lucidly written, generally well-illustrated and reasonably priced. It is heartily recommended.

JOEL G. SACKS, M.D.

ATLAS OF OBSTETRIC TECHNIC. J. Robert Willson, C. V. Mosby Company, St. Louis, Sept. 1969, \$19.75.

The atlas consists of excellent illustrations and clear, concise commentary. The text is well-written, easily understood, and coordinated with the drawings. It is more than a picture book in that the accompanying text delineates what is necessary in labor and delivery rooms, the care of patients on admission, and during labor and postpartum care. The chapter on Caesarean section includes both preoperative and postoperative care as well as the indications for the procedure. The author gives the reasons for complications and their effects. Abnormalities of labor and delivery, and the maneuvers for their correction are presented.

This second edition of the atlas has been expanded, and new material is presented on induction of labor, the third stage of labor, urinary estriol determination, placental localization, amniotic fluid evaluation, and anesthesia and analgesia. The book is primarily for residents and practicing physicians and is a very worthwhile reference text.

Paul D. Urnes, M.D.

A Measure of Bureaucracy

"I can tell you that taking a toy away from a four-year-old child is a lot easier than taking paperwork away from a bureaucrat."—Secretary of Commerce Maurice H. Stans.



THE VIEW BOX

BY LEON LOVE, M.D.

*Director, Department of Radiology, Loyola University Hospital
and Chairman, Department of Radiology, Loyola University
Stritch School of Medicine*

New-born infant in acute distress with considerable amount of abdominal distention. Physical findings revealed diffuse tympany throughout the abdomen with marked tenderness and no evidence of rigidity. What's your diagnosis?

1. Volvulus of the sigmoid.
2. Intra-abdominal abscess.
3. Pneumoperitoneum resulting from perforation of a hollow viscus.
4. Meconium peritonitis.

(Answer on page 657)



Fig. 1



Fig. 2

Rhinocytology

And its diagnostic possibilities

In allergy

BY LUCIA FISCHER-PAP, M.D./ROCKFORD

Nasal and bronchial smears for cytologic studies are a useful and accessible source of information in allergy. They often confirm or establish a diagnosis when the history is not definitive or the skin tests are uncertain. This is particularly true in the case of young children in the one to five age group, in whom mucus membrane sensitization and upper airway symptoms often appear much before there are enough skin sensitizing antibodies to give noticeable

reactions to suspected inhalants. The procedure is entirely harmless and free of danger, discomfort, or side effects. It can be repeated as often as necessary. The technique of collecting, fixing, and staining mucus specimens is simple, inexpensive and requires very little equipment. Anyone can do it well in any office corner with five minutes of training and five minutes to do it. Once fixed and stained, the slides can be saved, unchanged, for several months.

So far, the only cell universally sought in the nasal smear for diagnostic purposes has been the eosinophil. Goblet and mast cells have also attracted in recent years the attention of several investigators. The mast is a large cell which takes up many aniline dyes and contains numerous granules which stain well, metachromatically, with toluidine and methylene blue, among others. It is usually from two to three times the size of an eosinophil, round or irregular in shape (probably depending on its age) with large, intracytoplasmic granules that stain a deep purplish blue and sometimes cover the large central nucleus. The granules can also appear to be "falling out" of the cell at times, through a damaged or altered membrane. Other cells such as "goblets" which are modified epithelials, and polymorphonuclear cells have also been examined and assigned a certain diag-

nostic significance. The presence of bacteria and numerous neutrophils is considered a reliable indication of upper airway infection. No one cell in particular, however, has become, so far, as diagnostic of allergic disease in everyday practice as the eosinophil. Our purpose in this study was to examine two notoriously granular cells: the *eosinophil* and the *mast cell*, and once identified, attempt a correlation be-

Lucia Fischer-Pap, M.D., is a clinical associate in allergy at the University of Illinois and maintains a private practice in Rockford. A graduate of the Medical School at the University of Buenos Aires, she trained in allergy at the University of Illinois. She is also a member of the American Academy of Allergy and the Chicago School of Allergy.



tween their presence in the nasal mucus and allergy in general, as well as specific sensitivities in particular.

Bibliographic Review

It is now generally accepted that the eosinophils phagocytize Ag-Ab complexes. Their presence, therefore, in any tissue indicates that Ag-Ab complexes are being formed in that area and that an allergic or injurious reaction is taking place. According to Max Samter,¹ the Ag-Ab complex is the most reliable eosinotatic factor. Bryan and Bryan^{2,3} reported in 1959, an ingenious study in which they coined the word "cytogram" for the evaluation of nasal mucus cytology. They named and described a new epithelial cell, "the goblet cell," a large dilated, mucus secreting epithelial, which they considered diagnostic of allergic disease. They also advanced the theory that the mast cell has diagnostic meaning in food allergy, a rather new concept then and even now, but admitted that the eosinophils are the most abundant of all three types. The Bryans claimed, at the time, to be able to detect 86% of all cases of upper airway allergy by the nasal cytogram alone, concluding that all three—eosinophils, goblets and masts—are cytologic indicators of an allergic response. They also noted that the mast cell, like the eosinophil, disappears in acute inflammation but is present and increased in chronic inflammation. Masts, like eosinophils, are also made to disappear from the tissue by corticosteroids. Bryan advanced the theory that the "well fed" mast cells probably either make or store histamine. The eosinophils, in turn, dispose of or carry it away, once it is liberated from the damaged mast cell by a noxious substance.

Selye⁴ in his recently reviewed book about mast cells also makes a similar statement: "It is possible that eosinophils are attracted by degranulating mast cells (and basophils) to neutralize their products."

Shioda and Mishima⁹ in Japan, did a study in 1965, correlating sharply rising curves of eosinophils and mast cells in the nasal secretions with provocation by ingestion of specific foods, in food sensitive patients.

K. J. Johnson,⁷ on the other hand, had not been able to find any such relationship earlier in 1952, between nasal mast cells

and positive scratch tests to foods, or a positive history of food allergy.

And, to close this brief reference review, we must agree with Riley that today, almost 90 years after Ehrlich's discovery of the mast cell, there is still no complete knowledge or uniform agreement as to what, precisely, are its functions in the tissues.

Materials and Methods

Two hundred and forty sets of nasal smears were reviewed. All belonged to patients appearing for an allergy survey at our office or the Allergy Clinic of the University of Illinois. Smears from patients who were taking steroid medication orally or topically and the poorly stained ones were eliminated. The resulting group of 75 pairs were studied. This group will be the only one mentioned from now on.

The specimens were taken with a cotton applicator, manually tufted to slightly irritate the nasal mucosa, and stimulate the secretion of fresh mucus from the upper segment of both nasal cavities. They were then smeared on slides, air dried, fixed with alcohol, and stained with the Hansel stain consisting of eosine and methylene blue (Lide Lab. Inc., 634 North Grand Blvd., St. Louis, Mo.). Once stained, they were dried again with alcohol and by fanning in the air.

All slides were examined at first within a week of staining, and again a few months to one year later. When the first and second reports were compared, it was noticed that in several cases the eosinophils and other cells were seen less clearly the second time. Poor preservation of some of the cells with destruction of cytoplasmic structures was noticed, and all slides were from then on reviewed only once, while still fresh.

All cytologic examinations were made with an A O Spencer Binocular microscope, using the higher power under oil immersion, after having scanned the slide with the three lower powers (4x, 10x and 45x). All slides were reviewed by the same observer. As for the patient group, a few non-atopic patients were deliberately included for controls. The rest were all found to be atopic, by the end of this study.

Before attempting to summarize our results, we must include the few arbitrary definitions and classifications used:

Classification of Nasal Eosinophilia

- 0 -None seen
- 1+-A few seen
- 2+-A few clusters of cells seen
- 3+-Thick clusters throughout one slide
- 4+-Massive eosinophilic concentration throughout both slides.

(See Fig. 1 and 2)

List of Antigens Used and Strengths

(Usually measured in weight by volume.)
1:10 to 1:20 for scratch tests (usually 1:10)
1:100 to 1:1 million for I.D. tests (usually 1:1,000)
SEASONAL inhalants used: pollens; some seasonal molds.
ENVIRONMENTAL inhalants used: house dust; molds; feathers; kapok; animal hair; danders.
FOOD antigens used: milk; eggwhite; soybean; nuts; cereal grains; seeds; seafoods; fish; meats.
Each patient received from 15 to 60 scratches and from 4 to 25 intradermal tests. The average set was 30 scratches and 5 to 10 intradermal tests.

Grading of Skin Reactions to Scratch or I.D. Tests

- 0 -No Reaction
- 1+-Flare only, no wheal
- 2+-Flare and small wheal
- 3+-Larger wheal and flare, and one pseudopode
- 4+-Larger wheal and flare, and several pseudopodes

(All 1+ reactions were considered negative and disregarded entirely in this study. A positive reaction was a 2+ or larger.)

Arbitrary Definition of Atopic Patient at the End of the Study

(The group we started with was not classified until the end of the study.)

All patients in this study who fulfilled at least three of the following four criteria were considered allergic:

1. History of bronchial asthma, rhinitis, urticaria, angio-edema or eczema.
2. Positive skin reaction of 3+ or more to at least two of the antigens listed.
3. Positive eosinophilia in peripheral blood or mucus membrane.
4. Good response to antihistaminic or other anti-allergic medication.

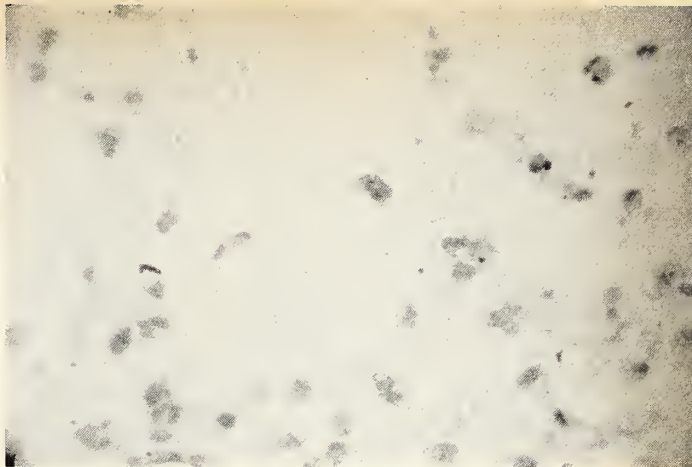


Fig. 1. Three plus nasal eosinophilia. (Lower power)

Atopy

	Patients Considered Atopic	Non-atopic Patients (controls)
Total	70	5
75	93%	7%
100%		

Findings
Inhalant Allergy

	Patients with Rhinitis	Patients without Rhinitis
Total	69	6
75	92%	8%
100%		

(We were dealing here, therefore, with a group of predominately allergic patients, in most of whom the upper airways were a part of the shock organ.)



Fig. 2. Three plus nasal eosinophilia. (Higher power)

Study of Our Group By Ages and Sex

<u>Ages in Years:</u>					
Infants	(0 to 2) = 6)	Total No. Children - 35	}	<u>Total 75</u>	{
Children	(3 to 12) =29)				
Young Adults	(13 to 20) =12)				
Adults	(over 20) =28)				
		Total No. Adults - 40			
(Sexes and ages equally well represented)					

Nasal Eosinophils In Atopics and Non-Atopics

Total No. Patients	Atopic Patients	Eosinophilia in	
		Atopics	Non-Atopic (controls)
75	70	57 or 81% of atopic group	5 1 or 20% of control group*

(Food sensitivity by history and skin tests was found in 26 patients or 36% of the total, but since most of them also had inhalant sensitivities, separate conclusions in this area could not be drawn.)

*A control group as small as this one is not statistically significant. All we can say is that *one non-atopic* patient also had nasal eosinophilia.

Mast Cells

The interpretation of findings in this area was much more difficult than with the eosinophils. To describe our mood, I will have to quote briefly one of R. Kipling's stories: "An old monkey and his little grandson were sitting on a tree, peeling bananas. The old monkey said to the young one, 'You know baby, you should be proud of yourself, for we, the monkeys, represent the highest form of life on Earth: . . . 'Really grandpa . . . ?,' said the young monkey. 'That's nice . . . , but why are we the highest form of life? I mean, . . . How do we know that?' The grandfather scratched his hairy forehead, ate his banana, meditated a while and finally replied, 'Why, because we have always said so!'"

Our identification of mast cells was the result of a process of elimination of other cells. Once the eosinophils, epithelial, neutrophils and bacteria were identified, we looked for large purplish-blue cells, with abundant granules. Unfortunately, we did not find them very often. The eosinophils are clearly visible and beautifully colorful cells. The mast cells in the human nasal mucosa seem to behave as the exact opposite. We have seen them in the nasal smear of allergic patients often enough to be intrigued by their presence, yet not often enough to assign them any diagnostic meaning.

Conclusion

Our conclusions, drawn from the bibliography as well as from our own study, are:

1. Rhinocytology is an open window to the study of upper airway allergy. It could become in the future as important to the allergist as the vaginal smear has become to the gynecologist; but it is diagnostic today only to a certain extent. Like skin tests,

it cannot entirely rule out atopy when negative, but it can help establish a diagnosis when other clear evidence is insufficient or lacking.

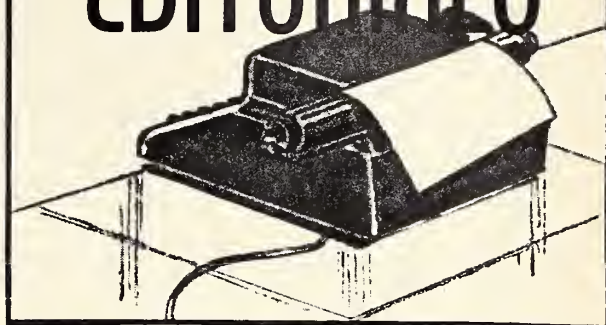
2. The eosinophils are still the most commonly found, easily identified, most abundantly seen cells related to allergy and the allergic tissue response. Although they will occasionally appear when there is only a "tissue injury" type of phenomenon, they have been shown to be present in high percentages in atopic patients, particularly those with inhalant allergies. They are still a much more reliable diagnostic index than the masts or any other cells, when inhalant allergy and mucus membrane sensitization are suspected.

3. Nasal mastophilia, if we are to call it that way, seems much less common. Although it also seems to be associated with allergic disease, masts and eosinophils do not appear to coexist at the same stage of the allergic process. Eosinophils, alone in large quantities, appear much more frequently than mast cells in large quantities or eosinophils and mast cells together. One possible explanation for this would be that in the process of releasing histamine, the masts are destroyed and become *no longer visible by the time intense eosinophilia appears on the slide*. The masts, even when found, are not as abundant, clearly seen or easily identified as the eosinophils. Therefore, (at least with the Hansel technique) they cannot be considered, yet, reliable diagnostic cells in the nasal smears of allergic people. ◀

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EDITORIALS



NEVER-ENDING TROUBLES

Universal voluntary health insurance programs are being advocated by several groups including the AFL-CIO, Gov. Nelson Rockefeller and even certain state medical societies. The medical profession continues to be blamed for hamstringing Medicare and Medicaid and contributing to spiraling medical costs. The opposition will stop at nothing and it is of the utmost importance to differentiate between medical care and health care, an all-inclusive term.

Labor leaders are the most difficult to understand and at times we think "they protest too much." After signing their first wage contract with Local 1199 last December, Johns Hopkins Hospital announced room rate increases averaging \$18 a day.

Labor unions are not much for charity and are now crying loud and clear that the

Government is paying too much for the care of the indigent and retirees. Physicians are billing the Government because Congress passed a law saying they should be paid. We are not only lambasted but have received no thanks for previously treating them at little or no cost.

Salaries mean very little to labor unions and they never bat an eye when criticized for contributing to inflation. The adage "If you can't beat 'em, join em" may soon be meaningful to the medical profession. By this we mean unionize, so that physicians could gain the same benefits and legal privileges afforded these groups. We realize that the very thought of doing this is obnoxious to our profession, but it may be the best offense in dealing with our future problems.

T. R. VAN DELLEN, M.D.

WIGGERY

An editorial in the *British Medical Journal* decried the high cost of wigs to cover the heads of elderly women with thinning hair. Dermatologists are allowed to prescribe wigs when considered a necessity. According to law, two wigs are allowed, one of which should be cleaned and set every month. Some hospitals are spending 2000 pounds a year (\$4,800 American currency) on the cleaning and maintenance of wig-gery.

The editorial sympathized with distraught grandmothers who feel they must have a wig, but believes that those who make these decisions should use more discretion and prescribe wigs only for those who qualify for the ancillary hairdos. According to the National Health Service

Act, those qualifying are bald due to congenital dystrophy of the skin; alopecia totalis; severe and longstanding alopecia areata; extensive scarring following trauma, X-ray, or an inflammatory condition. A wig is also considered necessary when temporary baldness follows an illness.

Wigs are frequently worn by English judges, barristers and other lawmakers. This may explain why they were so generous in their dealings with the National Health Service. There also has been a proposed increase in patient's payments for teeth and spectacles. But spending almost 1 million pounds (more than 2 million American dollars) a year on wigs is madness. ("Wigs and Waste," *Brit. Med. J.* (Leading Articles), Dec. 20, 1969, page 702.)

T. R. VAN DELLEN, M.D.

Adaptation Of Cardiac Catheterization Techniques For Insertion of Intravascular Cardiac Pacemakers

BY THOMAS G. BAFFES, M.D., WILLIAM J. BLAZEK, M.D., AND IRVING J. ADATTO, M.D.
/CHICAGO

Introduction of cardiac pacemakers for treatment of complete heart block was once a formidable procedure because it required thoractomy. Now, operative risk has been greatly reduced by development of intravascular pacemaker electrodes that make it possible to use the transvenous route for pacing the heart. Recent development of the "demand" pacemaker has further ex-

tended pacemaker application by decreasing the danger of ventricular fibrillation, by permitting cardiac pacing with a stronger impulse so that endocardial fibrosis can be more easily surmounted, and by avoiding the discomfort of competition between a fixed pacemaker and a heart whose spontaneous rhythm has been restored by pacing.

Cardiac pacing has now been perfected to the point where it can be applied to partial block, arrhythmias and even on a prophylactic basis in patients in whom heart block is considered imminent. It is not uncommon to see cardiac pacers introduced in patients of very advanced age who are extremely ill. The keystone of this wide

applicability, in addition to improvement of pacemaker units, is the ease with which the intravenous electrode can be introduced into the lumen of the right ventricle through the systemic veins. This facility has resulted largely from adaptation of methods and equipment that were originally developed for the cardiac catheterization laboratory.

Clinical Results

One hundred thirty-one patients with heart block have come to our attention. In some, the problem occurred acutely, in conjunction with sudden myocardial infarction. In others, the onset was gradual and did not present itself as a clinical emergency. Many recovered after establishment of temporary pacing. One hundred ten patients eventually required introduction of permanent intravenous pacemaker electrodes. In the early patients in this series, the pacemaker power packs were of the "fixed" type with predetermined rate of electrical discharge. Recently, patients have had introduction of the "demand" type so that competition with spontaneous

Thomas G. Baffes, M.D., is attending surgeon at Augustana Hospital, Swedish Covenant, Illinois Central and Lutheran General. William V. Blazek, M.D., (bottom left) is a consultant in cardiology. Irving J. Adatto, M.D., (bottom right) is director of the Coronary Care Unit at Lutheran General Hospital. Partially supported by funds from the Nelson M. Perry Research Institute, Augustana Hospital.



heart beats is avoided. Furthermore, as the fixed pacemakers come due for replacement, more and more of the "demand" type power packs are being introduced in their place.

The intravenous electrode, usually through the jugular vein, has become an excellent method for establishing cardiac pacing in the elderly with minimal operative mortality. There was only one immediate postoperative death in the one hundred ten patients requiring permanent intravenous pacemaker electrodes (operative mortality=0.9%). This patient died three days postoperatively of cerebral damage resulting from multiple attacks of syncope that occurred before he arrived at the hospital for introduction of the pacemaker. It is remarkable that more patients did not expire, for many of them were operated upon after having sustained multiple attacks of syncope or while in cardiac failure because of inadequate cardiac output resulting from severe bradycardia. This high salvage rate results from two factors: (1) An intravenous pacing electrode and a "demand" pacemaker power pack are kept in stock and sterile in the operating room, so that they are instantly available, and (2) the emergency crews in the operating room and the X-ray department know how to operate the image intensifier equipment so that it is available on very short notice.

As more and more of these patients survive, new problems arise, because the readily accessible venous routes for introducing intravascular cardiac pacing tend to become exhausted with each succeeding electrode replacement in a given patient. The methods to be described below, then become even more valuable for facilitating introduction of transvenous intracardiac pacing.

Use of the Image Intensifier for Positioning Electrodes

The image intensifier has become a most essential tool in intracardiac pacing. Since it provides visualization of the heart and the intravascular electrode with much less

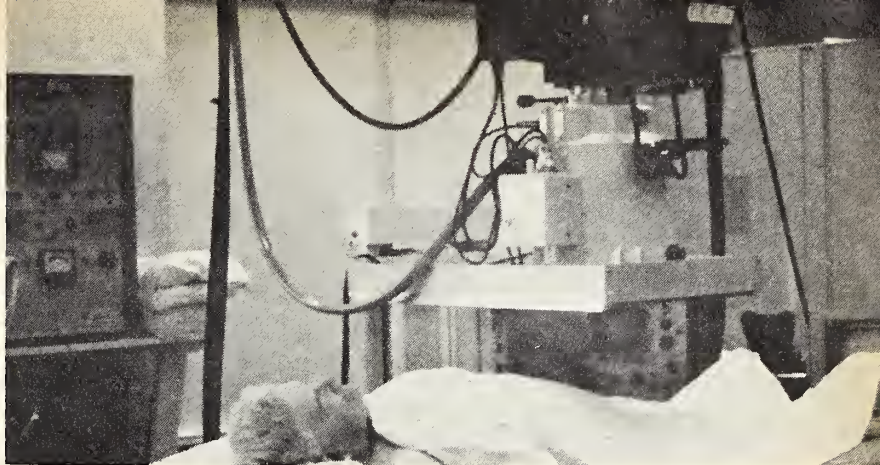


Fig. 1-A Photograph of an image intensifier and ancillary equipment utilized for insertion of the intravascular electrode. The 9-inch scope is visible over the patient. To the left is a defibrillator. Beyond the scope, in the background, is a television monitor, which permits direct viewing of the electrode as it is being inserted.

irradiation than ordinary fluoroscopy, it permits adequate fluoroscopic monitoring of the heart and the pacemaker components during and after introduction of the pacing electrode. Movement and position of the electrode and the implanted power pack may be observed while the patient is coughing or moving. The stresses, to which they are subjected while the heart is beating, may be accurately assessed before closure of the operative incision, and the position of the electrode may be altered as needed during the operative procedure in order to assure firm contact with the endocardium without undue distortion (Fig. 1-A).

The image intensifier is also invaluable for detecting sources of difficulty if the pacemaker subsequently fails. The causes for failure may not be obvious on simple roentgenogram of the chest. The image intensifier may demonstrate subtle breaks in the pacemaker electrode or faults in its position not apparent unless viewed under motion or stress (Fig. 1-B). The opportunity to view fluoroscopically the function and position of the electrode with the heart in motion or with the patient in changing positions is invaluable for this purpose. Even perforation of the electrode through the wall of the myocardium, from within the lumen of the right ventricle, has been diagnosed by observation, that the tip of the electrode has protruded beyond the confines of the heart shadow during fluoroscopic examination of the beating heart. Of primary importance is the fact that the information derived with the image intensifier is available immediately and within the



Fig. 1-B. Roentgenogram (spot film) showing distortion produced in an indwelling, intravascular pacemaker electrode, made obvious by hard downward traction on the patient's arm as it was held parallel to the thorax. This break in the electrode was not detected by normal chest roentgenograms, because it was not obvious until the patient's arm was distorted by downward traction. The patient had been admitted because of periodic recurrent paroxysmal syncope associated with bradycardia. The break in the pacemaker electrode was not detected until the patient was fluoroscoped with the image intensifier and the arm was manipulated into a variety of positions.

sterile environment of the cardiac catheterization laboratory or the special procedures room. As soon as the diagnosis is made, operative correction may be embarked upon with very little delay.

Use of Guide Wires and Cardiac Catheter Techniques

Perhaps the best example of the adaptation of cardiac catheterization principles to the introduction of intravenous pacemakers is the design of the intravascular pacemaker electrode itself (Fig. 2). It consists of a coiled, stainless steel, wire electrode coated with silastic, and equipped with positive and negative platinum contact cylinders at the tip. The coiled wire electrode has two central guide wires, each of which gives firmness and permits manipulation of the intravenous electrode within the venous system into the chambers of the heart, until it comes in contact with the endocardium of the right ventricle. When inserting the electrode, it is frequently necessary to bend the tip of the guide



Fig. 2. Photograph of the intravenous pacing electrode and the attached power pack. The coiled tip allows manipulation of the catheter into position against the endocardium of the heart. This is done before the power pack (upper left) is attached. The guide wires (not shown) were removed before the power pack was attached.

wire in order to achieve a curve at the tip (Fig. 3). The firmness of the guide wires and their intrinsic curvature (induced by bending) greatly facilitate manipulation and introduction of the electrode. When the electrode is firmly wedged against the right ventricular endocardium and capture of the cardiac rate is confirmed, the guide wires are removed so that the electrode is flexible and able to bend with the motion of the heart and the diaphragm. This flexibility permits the electrode to tolerate stress of bending and twisting inside the heart for long periods of time.

Sometimes even an ordinary cardiac catheter may be useful in the insertion of an intravenous pacemaker electrode. On these occasions, the junction of the jugular, cephalic and subclavian veins is such that the pacemaker electrode, even with properly formed guide wires, cannot be inserted around a circuitous venous route into the right ventricle. The ordinary cardiac catheter, being thinner and more maneu-



Fig. 3-A. View of the central guide wire inserted into the pacemaker electrode to give it enough firmness for introduction into the vascular system and against the endocardium of the heart.

verable, can be inserted with relative ease via an antecubital vein into the right ventricle. If the pacemaker electrode can be inserted via the jugular vein until it comes into contact with the standard cardiac catheter, it may follow the standard catheter by capillary attraction along the circuitous venous channels and eventually find its way along the same route into the right ventricle. Although this method does not always work, it has been useful for solving some difficult problems in introducing the pacemaker electrode.

Ordinary techniques for "looping" standard cardiac catheters into the right ventricle have also been used for introducing the intravenous pacemaker electrode. Perhaps the most common situation requiring these maneuvers is that in which the intravenous pacemaker electrode is continuously directed from the jugular vein laterally into the subclavian and the axillary veins, and cannot find its way directly into the superior vena cava because of some peculiarities in the venous anatomy at the base of the neck. In these instances, the electrode tip is wedged laterally into the axillary vein and the wire stylet is withdrawn until the central section of the electrode buckles into the superior vena cava. Further introduction of the electrode then usually forces a significant portion of it into the upper aspect of the superior vena cava. Manipulation of the guide wires and the electrode can usually maneuver the electrode tip into the superior vena cava. After that, the electrode tip can be directed in the usual fashion into the right ventricle.

Angiography and Cinefluorography

Although angiography is not absolutely essential for introduction of the intravenous pacemaker electrode, it may prove useful for detecting venous anomalies or unsuspected venous thrombosis of tributaries of the superior vena cava that create unexpected obstacles to passage of the pacemaker electrode into the right atrium (Fig. 4). Injection of contrast medium, with simultaneous photography or simple viewing of its passage on the television monitor, may demonstrate these anomalies, and avoid fruitless prolonged manipulation of the electrode, with frustration of the operating team and exhaustion of the patient. In the case of emergency introduction of

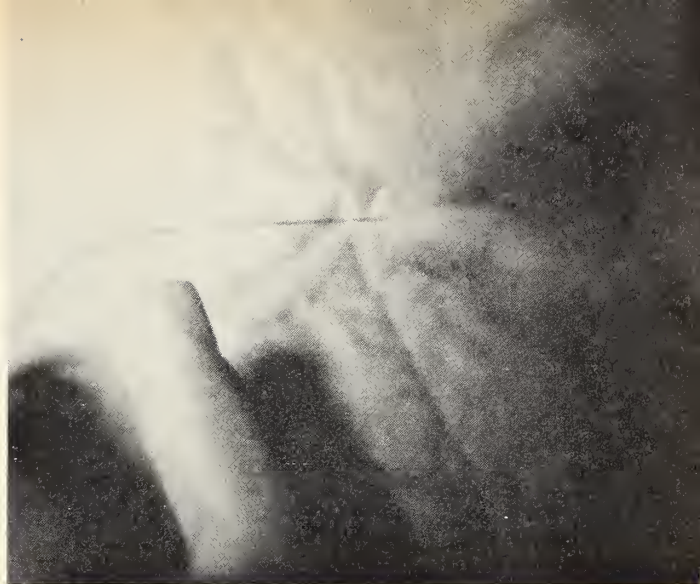


Fig. 3-B. Photograph showing how the thumb and forefinger are used to create a curvature in the tip of the guide wire to be inserted into the pacemaker electrode. This induced curvature produces the curvature in the electrode tip demonstrated in Fig. 2

a pacemaker, such rapid information may, of course, be vital to the safety of the patient by preventing undue delay in establishing cardiac pacing.

Angiography becomes particularly valuable in patients having repeated pacemaker operations. As the number of patients having successful pacemaker insertions increases, we can anticipate an increase in the number of repeated pacemaker electrode introductions, because electrodes eventually can be expected to break under repetitive stress caused by cardiac contraction or motion of the diaphragm. As the availability of venous channels decreases,



Fig. 4. Venogram showing obstruction to the subclavian vein at the thoracic inlet. This is obviously not a desirable route for introduction of a temporary or permanent intravascular electrode.

more and more ingenuity is required to find a fresh route into the right ventricle. With these developments, angiography can be expected to assume a more and more significant role in pacemaker therapy, especially since transvenous pacing becomes critical in elderly patients too old to permit safe thoracotomy and direct epicardial pacing electrodes.

Cinefluorography has proven useful for making a record of the motion and position of the pacemaker electrode for future reference, especially in patients in whom capture is difficult or the position of the pacemaker electrode is eccentric. It also has been utilized to record pre-operative contractions as a means of evaluating improvement of ventricular function following pacemaker therapy.

Special Techniques

Though not directly related to the main subject of this paper, it is essential to emphasize that a lot of other ancillary equipment is required to supplement the image intensifier in order to assure safe, efficient introduction of the intravenous pacemaker electrode (Fig. 1). An electrocardiograph, preferably with an oscilloscope for direct viewing, is mandatory for monitoring the patient during surgery. It is used to evaluate the threshold and polarity of the wedged intravascular electrode before attaching it to the pacemaker power pack, and in order to confirm successful capture of the heart rate by the pacemaker before closing the operative incisions. The patient should always have intravenous fluids running during insertion of the pacemaker, and in those individuals with severe bradycardia, intravenous Isuprel may be valuable for preventing asystole or syncope until full pacing can be established. It is also mandatory to have available equipment for emergency defibrillation and external pacing as well as drugs for cardiac resuscitation. These materials and equipment are usually already available in a well-equipped cardiac catheterization laboratory. If the pacemaker is inserted in a special procedures room connected with the X-ray department, it is advisable to provide them in the form of an emergency cart that can be wheeled into the special procedures room whenever a pacemaker is being inserted (Fig. 5).

The development of percutaneous (transvenous) and transventricular methods for inserting cardiac catheters has made possible emergency insertion of flexible pacemaker electrodes via these routes in patients in whom there is little time or opportunity for insertion of the conventional transvenous pacemaker electrodes under fluoroscopic control. Flexible, temporary, Teflon coated pacing electrodes have been developed, that may be inserted through an antecubital or other appropriate distal vein (e.g. subclavian), and "floated" progressively along the venous return to the heart into the right atrium and thence, into the right ventricle. Typical electrocardiography patterns have been described, which help locate the position of the electrode tip under emergency conditions where there isn't time to activate the image intensifier. Unipolar or bipolar pacing of the heart can be established once the position of the flexible electrode tip has been veri-



Fig. 5. Photograph of emergency cart with defibrillator, monitoring oscilloscope for electrocardiogram, drugs and emergency cutdown equipment and syringes for immediate use in the special procedures room. The cart is mobile, making its availability possible in other areas of the hospital when it is not needed in the special procedures room.

fied by electrocardiography. A similar pacing electrode has been developed for insertion by the transventricular transthoracic route via a needle puncture in the left pre-sternal area. This, of course, is recommended only in extreme emergency conditions when a patient is encountered with acute cardiac asystole in the emergency room or under similar conditions where minutes are precious and there is no time to move the patient to the image intensifier. These measures are usually required for severely infarcted hearts and do not always re-establish cardiac contractions. Yet, they provide another useful method for attempting cardiac resuscitation in severe emergency conditions.

Summary

1. The adaptation of principles and techniques for cardiac catheterization for facilitating introduction of intravascular pacemaker electrodes has been described.

2. These principles have been applied to 131 patients who require some type of intravascular pacing. One hundred ten of these patients required introduction of permanent intravenous electrodes.

3. The operative mortality for permanent intravenous pacing in this series was low. The high rate of success in these patients resulted from ready availability of the pacemaker power pack and the intravascular electrode, as well as the rapid accessibility of the image intensifier for immediate use in case of emergency. ◀

Spinal Brace Studied

Braces used to correct curvatures of the spine in youngsters are the focus of a research project at the University of Illinois Medical Center Campus, Chicago.

With an initial grant of \$48,158 from the Department of Health, Education and Welfare, the research of an orthopedic surgeon and an engineer is aimed at giving physicians more enlightened methods of treating spinal curvatures, a common malady occurring in adolescents.

It will give physicians objective methods of evaluating the effectiveness of the "Milwaukee Brace" in straightening lateral curvatures of the spine, said Dr. Jorge Galante, assistant professor of orthopedic surgery in the U. of I. College of Medicine.

If used improperly, the brace, which extends from the waist to the chin, may produce complications.

Dr. Galante hopes to give fellow orthopedic surgeons a set of new criteria that will help them determine in a short span of time if the brace is actually helping a patient and how to adjust it to maximize its effectiveness for a particular patient.

Under present methods, the Milwaukee Brace is worn (24 hours each day) for an average of four years. Poor fittings can cause dental and facial deformities from the pressures exerted by the brace. Extreme pressures from the brace can also cause coughing and vomiting.

In the first year of the research project at the University's Scoliosis Clinic about 60 patients wearing Milwaukee Braces have

been used to measure the forces. It has initially been found that patients whose curves become worse while using the brace usually are subjected to the greatest forces.

In the months and years ahead, the researchers hope to determine how the Milwaukee Brace might be modified to improve its effectiveness. The research may lead to the development of a new type of spinal brace, but this is not its major focus at this time, Dr. Galante said.

The Milwaukee Brace was developed in 1958 by a group of physicians and has increasingly been used as a non-surgical method of correcting "idiopathic scoliosis," a lateral curvature of the spinal column. This malady most often occurs in adolescent girls; if left untreated, it can cause severe deformities of the spine.

An important adjunct to the U. of I. research is an intense study of the spine to identify the various causes for curvatures.

Drs. Schultz and Galante have developed a mathematical model of the human spine in an effort to learn more about its mechanical operations.

"Perhaps the most significant result of the initial studies is that they clearly demonstrated that the vertebral column is not geometrically constrained to have a "pattern of motion" but can achieve many different configurations in a variety of ways," Dr. Galante said.

Initial studies indicate that the mathematical models of the spine are reasonable representations of real spines.

public affairs library reviews



BUREAUCRACY. By Ludwig von Mises, Arlington House, New York, \$5.00

Ludwig von Mises is internationally known as the leading exponent of the Austrian School of Economics and is the author of a shelf of major books dealing with economic theory and social practice. Until his retirement in mid 1969, he taught at the Graduate School of Business Administration at New York University.

"There are two methods for the conduct of human affairs within the frame of human society," writes Ludwig von Mises. "One is bureaucratic management, the other is profit management." In this book, Dr. von Mises provides the knowledge and the

insight necessary for a national appraisal of the two.

The author does not condemn bureaucracy per se. He shows where it is useful and necessary. But then he sets out in bold relief where bureaucracy is a disaster—when it substitutes government action where private enterprise ought to prevail.

The long conflict between individualism and collectivism continues to divide mankind into two hostile camps. Today many advocates of omniscient government are less sure of themselves. Thus, at long last, this prophetic look at the contrast between bureaucratic and business management could have its day.

Obituaries

***Herman Blustein**, Chicago, died in April at the age of 53. He was a psychiatrist at Veterans Administration Hospital.

***Alice W. Hamby**, Elmhurst, died April 13 at the age of 46. She was on the staff of Elmhurst Memorial Hospital.

***Erwin L. Hirsley**, Western Springs, died March 23 at the age of 61.

***Harry Jackson**, Chicago, died April 21 at the age of 89. He was a member of the ISMS Fifty-Year Club.

Robert J. Kamish, Wilmette, died April 4 at the age of 61. He was assistant director of the American College of Surgeons.

***Paul T. Lambertus**, Quincy, died April 1 at the age of 60. He was past president of the Adams County Medical Society

James A. Megahy, Chicago, died April 9 at the age of 86.

***Edwin Netzel**, Chicago, died February 21 at the age of 50. He was on the staff of Bethany Methodist and Ravenswood.

***Franklin T. O'Connell**, Evanston, died April 20 at the age of 73. He was a past president of the St. Francis medical staff.

***James B. O'Neill**, Palos Heights, died in

April at the age of 52.

***Harrison C. Putman, Jr.**, Peoria Heights, died March 17 at the age of 52. He was past president of the Peoria Medical Society.

***Oscar G. Schnetzer**, Chicago, died April 17. He was a member of the ISMS Fifty-Year Club.

***Ernest D. Seymour**, Streator, died March 21 at the age of 92. He was a member of the ISMS Fifty-Year Club.

***Danely P. Slaughter**, Northfield, died April 11 at the age of 59. He was past president of the Illinois division of the American Cancer Society. He was cited in 1969, for his "outstanding service in cancer control" and for his work as chairman of the commission on cancer of the American College of Surgeons.

***George W. Staben**, Hudson, died April 4 at the age of 78. He was a member of the ISMS Fifty-Year Club.

***Paul J. Wolf**, Chicago, died April 6 at the age of 77. He was a member of the ISMS Fifty-Year Club.

*Indicates member of the Illinois State Medical Society.

Reading and Learning Problems

Ophthalmological Management

BY LAWRENCE J. LAWSON, JR., M.D./EVANSTON

Vision and Reading

Currently there is a great interest by both educators and the general public in children who underachieve academically. There is a vast amount of conflicting information about these children—both as to diagnosis and appropriate therapy. Ophthalmologists are daily requested by anxious parents to evaluate the status of vision and prescribe treatment to improve the scholastic performance. Since we are often the first ones consulted, what is the present state of our knowledge?

A Scottish ophthalmologist, Hinshelwood,¹ in 1895 first described an inborn defect which was not the result of disease or trauma, that affected visual memory and resulted in a form of word blindness. Numerous authors have subsequently proposed various theories on the role of the eyes in the learning process and recommended a wide variety of therapeutic regimes which are reviewed elsewhere.²

It is important to recognize the child with a potential learning problem in early school years. Research is now in progress to delineate these children in the preschool and kindergarten years. Schiffman,³ has reported that if afflicted children were recognized before the second grade, 82% could be brought up to grade. If delayed until the third grade, only 46% could be brought up to grade, and if unrecognized until the seventh grade, only 10-15% could be suc-

cessfully treated. He is further studying these children and early results tend to show a high rate of "relapse" in those who were identified in the later school years. To ignore those who underachieve, and hopefully await the "late bloomer," is to deny aid to those who need it, and to allow secondary emotional factors to develop which complicate the treatment and reduce the prognosis for a satisfactory result. Diagnostic procedures are important in reading problems since they determine guidelines for the remedial program.⁴

Witty and Kopel⁵ conducted a large and statistically accurate survey on learning problems. They could find no single eye defect which was the cause of reading disabilities. These authors warned against the oversimplification of the reading process, which involves not only visual-perceptual processes, but also neurologic, emotional and general body factors. They did stress, however, that normal vision is essential for maximum attainment of reading efficiency, and that a search should be made for visual difficulties in each case of reading disability.

Ophthalmologists must be aware of the factors involved in reading disorders and have a method of evaluating, advising and referring these children for subsequent treatment. The approach is based on a positive attitude that the child is not "stupid" and that constructive measures can accurately determine the specific area of difficulty, and a remedial program can be

devised to assist the youngster in his academic progress. This requires communication with the other specialists involved in reading problems—the interdisciplinary approach. Those who state that nothing is wrong with the child demonstrate their own ignorance of the problem and a lack of concern for the patient. It is not proper to subject the child to expensive and prolonged treatment in the visual area when more comprehensive testing determines that the defect is more extensive and requires specialists in other areas—psychology, neurology or education. It is the responsibility of the practitioner to recommend procedures beyond the competence of his own field of specialization. Perceptual problems are seldom found in isolation, but are usually associated with other systems and etiological factors. To treat only one aspect of a problem is to court disaster.⁶

Reading problems are not directly related to refractive errors. Reduced visual acuity may cause ocular fatigue and slow the reading rate and comprehension, but will not cause reading retardation or reversal of letters. If vision is impaired sufficiently to interfere with the learning of the normal reading process, it will reduce general academic underachievement rather than produce dyslexia.⁷ Poor vision must be bilateral to interfere with learning.⁸ Poor readers do not have any type of refractive errors which distinguish them from normal readers, but when significant refractive errors are present, their correction improves reading efficiency of both retarded readers and normal readers. There is no vision screening device that can select those with visual problems which influence learning. The use of “reading glasses” (less than +1.00 sphere) to treat reading problems is considered to be a placebo. Their use is not recommended as it creates false security for the parents and postpones further evaluation for the specific area of most beneficial treatment.

Astigmatism should be corrected only when sufficient to impair visual acuity or produce ocular symptoms.⁹ Bifocals in children are indicated only in the presence of a binocular coordination problem in the reading range associated with an abnormal accommodation-convergence relationship. Prisms are selectively indicated on those with fusional problems or poor convergence.

Dominance

The significance of crossed dominance is confused in its relation to learning problems. Duke-Elder¹⁰ reported that in a normal population, 40% of right-handed individuals were left-eye dominate, and 50% of left-handed people were right-eyed. Zangwill¹¹ has stated that there is positive proof of asymmetric functioning of the two hemispheres and that there is no scientific evidence of a dominance relationship between the two halves of the brain. Myklebust¹² has recently pointed out that evidence indicates that verbal learning occurs in most individuals in the left hemisphere, and non-verbal learning is centralized in the right hemisphere. Shearer¹³ has reported a higher incidence of mixed preference in good readers than in poor readers. Numerous reports¹⁴⁻¹⁸ indicate that there is no significant difference in dominance between good and poor readers. Belmont and Birch¹⁹ studied dominance factors and stated that right-left awareness stabilized by the age of seven, hand dominance by the age of nine, and eye dominance is firmly established by the age of ten years. Berner and Berner²⁰ established the concept of the “controlling eye” as used in binocular acts as opposed to the dominant eye used in monocular acts. They proposed that shifting the controlling eye to the same side as the dominant hand would improve reading problems. This has become the basis for a portion of the Delacato technique. The theories proposed by Delacato have raised questions and been investigated by several authors,²¹⁻²² who have failed to confirm his claims. An Executive Board Statement of the American Academy of Pediatrics and the American Academy of Neurology has been issued,

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which states that there is no firm evidence to substantiate the claims made for the Doman-Delacato methods and program. A similar statement²³ concerning Institutes for the Achievement of Human Potential, which exist in many of the larger metropolitan areas, has been published and endorsed by ten national and international organizations.

Benton²⁴ reported encouraging results utilizing Berners' and Delacato techniques, plus drug therapy. His series, however, does not have scientifically accurate statistical information, nor does it allow for the Hawthorne effect. Shearer²⁵ condemns this approach until scientific appraisal is conducted to verify the results. Bender²⁶ has questioned the ability to change dominance. She stated that a child can be trained to use one hand or eye or to acquire skill by this means, but the actual dominance is not changed at the cerebral level. She further doubts that anything is accomplished by these methods of attempting to change dominant eyes-hand in dealing with dyslexia.

Stereopsis and Fusion

Coordination defects are not the primary cause for dyslexia. Ocular motor problems do not interfere with the recognition of symbols. Three recent studies^{27,28,29} independently conducted evaluation of depth perception and fusion, and found a negative correlation with learning problems. Orthoptics or visual training is indicated only for such conditions as amblyopia, suppression, deficient binocular vision or poor fusion. Several authors have stated that if beneficial results are obtained by such training, it is through psychological effects of a positive approach to the child, by increasing his motivation and concentration, decreasing his anxiety and as a result, continuing maturation. These procedures must not be carried out to the exclusion of other remedial techniques and comprehensive diagnostic studies. Dunlop³⁰ proposed that corrective eye muscle surgery should be performed on those children with reading problems who had relatively minor muscle imbalance. His study revealed that ten to 15% of the dyslexic group might benefit from this surgery, but these findings have not been confirmed by other investigators.

Developmental Vision

A small but aggressive group of optometrists has been promoting the developmental vision theory. They consider that when eye movements are skillful, the child is ready to learn and interpret what his eyes are telling him. Eye-hand coordination is a primary requirement to the acquisition of knowledge; as expressed by Getman and Kephart,³¹ "it is the lack of the fundamental development in eye-hand coordination which accounts for the poor readers in our educational system." The treatment techniques of the developmental vision school employ a wide variety of educational and sensory-motor perceptual data to treat abnormalities in the learning area.

Cratty³² has reviewed Kephart's work in his laboratory and summarized that "the suggestion that motor learning influences perceptual processes" is at best imprecise, and at worse misleading. He further reports that no significant gains in reading competency will be achieved by participation in the techniques outlined by Kephart. In reviewing Getman's proposals, Cratty states that supportive research is sparse, while studies containing evidence that children who underachieve may have problems other than those involving eye function are numerous. The application of a program of visual training to large undefined populations of children suffering from educational difficulties is less than sound.

Carlson and Greenspoon³³ investigated the various claims for positive results of this approach and could not verify the findings. They state "most of the material is unsubstantiated and pseudoscientific and is based on evidence which is not scientifically accurate." They further condemned the optometrist who works alone in the perceptual motor and re-educational area since they are not adequately trained in these areas and cannot appreciate the necessity for more accurate psychological and educational evaluation and therapeutic programming. Any type of visual training should not be started until the child has been thoroughly evaluated to determine when the child will benefit most from this type of therapy. Proper consideration of the neurological status, the presence of a developmental lag, emotional or social maturity factors is ideally determined by the

interdisciplinary approach.

Frostig³⁴ stressed that training in visual perception should not be pursued in isolation, but integrated with training in sensory-motor and language functions. Scientific data are lacking to establish whether visual perception can be trained, and if perceptual capacity is trained, in what manner it can modify the learning process. Taylor³⁵ investigated reading skills and found a minimal control of the eyes in reading. His studies revealed that a conscious effort by the reader to improve the mechanical performance is undesirable, since it results in a lowered comprehension because the child is concerned with how he is reading, rather than what. Abnormal eye pattern movements are neither the cause nor the effect of poor reading. Teaching reading skills may improve the eye movements, but not the comprehension. Kephart³⁶ recommends that teachers evaluate ocular pursuits movements and train them when necessary. The role of abnormal visual pursuits in relation to learning is controversial. Goldberg³⁷ has emphasized that faulty eye movements do not cause poor reading, but are the result of poor understanding of the printed word. If abnormalities of ocular movements are noted, it is not the proper role of the teacher to treat them, but to request ophthalmological appraisal. Silver³⁸ clearly states that it has not been established that perceptual abnormalities are caused by defects in ocular pursuit patterns, or that training the voluntary component of eye muscle movements can improve perception and learning. Rosen³⁹ studied perceptual training and reading achievement in the first grade and concluded "that the additional time devoted to regular reading instruction might be considered more important for the pupils' reading outcome than the time

devoted to the specific types of perceptual training activities."

Conclusions

The ophthalmologist has the responsibility to evaluate the visual status, the binocular abilities, for neuro-ophthalmological deficiencies and to offer treatment as indicated for these children with reading and learning problems. If no abnormalities are noted, a positive suggestion should be emphasized to further evaluate the child. The pediatrician must rule out general health factors and assess the need for drug therapy to alleviate hyperactivity. A referral to a pediatric neurologist may be indicated. Certainly a psychological examination is necessary to determine the potential intellectual capacity and areas of normal and deficient performance. This total information must be coordinated with the educator. As Rosner⁴⁰ has stated, "Dyslexia is a category which is first and foremost educational. It is the educator who must deal with it in the most meaningful way and it is the educator who needs to prescribe treatment for the problem. Other disciplines make valuable contributions, but they are peripheral rather than central. In the final analysis the youngster must receive treatment for reading problems with a skilled remedial teacher."

It is necessary to provide an understanding of known facts without bias. We must be alert, and unwilling to accept simple explanations without real logic and scientific analysis. ◀

Bibliography

The bibliography for this article can be obtained by writing to: *Illinois Medical Journal*, 360 N. Michigan Ave., Chicago, Ill. 60601.

Tax Dollars Paying The Piper

"In fiscal year 1970, the U. S. government must pay \$17 billion in interest on the debt it has already accumulated. In 1941, the total federal budget was only \$14 billion. So it is costing Uncle Sam \$3 billion more to meet his simple interest obligations than it cost him to run the whole works just prior to World War II."—Jenkin Lloyd Jones, president, Chamber of Commerce of the United States.

NEW

PHARMACEUTICAL

SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

A New Drug Application has been granted by the U.S. Food and Drug Administration for the following new drugs.

Lithium Carbonate: Control of manic episodes in manic depressive psychosis.

ESKALITH: Manufactured by Smith Kline & French.

LITHANE: Manufactured by Pfizer.

LITHONATE: Manufactured by Rowell.

Rubella Virus: Immunization against German measles.

Vaccine, Cendehill

Strain

CENDEVAX: Manufactured by Smith Kline & French.

COMBINATION PRODUCTS

COLREX COMPOUND Cough and Cold Preparation Capsules R

Manufacturer: Rowell

Composition: Codeine phosphate	16 mg.
Papaverine HCl	16 mg.
Acetaminophen	300 mg.
Chlorpheniramine maleate	2 mg.
Phenylephrine HCl	10 mg.
Ascorbic acid	100 mg.

Indications: Symptomatic relief of acute respiratory disorders.

Contraindications: Use with caution in cardiovascular disease, thyrotoxicosis and diabetes. Not recommended for children under 6.

Dosage: Children 6-12: 1 capsule 3 or 4 times daily.

Adults: 1 or 2 capsules 3 or 4 times daily.

Supplied: Capsules

IBERET-FOLIC-500 Hematinic with Vitamins R
Manufacturer: Abbott

Composition: Ferrous sulfate	525 mg.
Folic acid	350 mcg.
Ascorbic acid	500 mg.
Vitamin B ¹²	25 mcg.
Other components of Vitamin B complex	

Indications: Iron deficiency anemia, especially when accompanied by possible folate deficiency.

Contraindications: Pernicious anemia

Dosage: One tablet daily.

Supplied: Controlled release tablets (Gradumet)

MUDRANE-2 Bronchodilator R

Manufacturer: Poythress

Composition: Potassium iodide	195 mg.
Aminophylline	130 mg.

Indications: Emphysema

Contraindications: Iodide: Tuberculosis, pregnancy.

Aminophylline: Applicable side effects and cautions.

Dosage: One tablet with full glass water, 3 or 4 times daily.

Divide tablet for child's dose.

Supplied: Tablets

NATALINS Rx Vitamins-Prenatal R

Manufacturer: Mead Johnson

Composition: Vitamin A	6000	USP units
Vitamin D	400	USP units
Vitamin E	15	Int. units
Ascorbic acid	100	mg.
Thiamine	1.5	mg.
Riboflavin	2	mg.
Niacinamide	20	mg.
Pyridoxine	10	mg.
Cyanocobalamin	8	mcg.
Folic acid	1	mg.
Pantothenic acid	15	mg.
Calcium	350	mg.
Iron	40	mg.
Copper	2	mg.

Indications: Prevention of megaloblastic anemia in pregnancy.

Contraindications: Hemochromatosis, Wilson's disease and pernicious anemia.

Dosage: One tablet daily.

Supplied: Tablets.

RATIO Antacid o-t-c

Manufacturer: Warren-Teed

Composition: Calcium carbonate	400 mg.
Magnesium carbonate	50 mg.

Indications: Gastric hyperacidity associated with heartburn, gastritis and peptic ulceration.

Contraindications: Hypermagnesemia, hypercalcemia or alkalosis.

Dosage: Chew or swallow 1-4 tablets, preferably 1 hr. after meals and as needed.

Supplied: Tablets

STRESSTABS 600 Vitamins o-t-c

Manufacturer: Lederle

Composition: Vitamin B ₁	15 mg.
Vitamin B ₂	15 mg.
Vitamin B ₆	5 mg.
Vitamin B ₁₂	5 mcg.
Vitamin C	600 mg.
Niacinamide	100 mg.
Vitamin E	30 units
Calcium pantothenate	20 mg.

Indications: Vitamin deficiencies which accompany physiologic stress.

Contraindications: None mentioned.

Dosage: 1 tablet daily, or as directed.

Supplied: Tablets

VANSEB Anti-dandruff Shampoo o-t-c

Manufacturer: G. S. Herbert (Div. Allergan)

Composition: Sulfur
Hexachlorophene
Salicylic acid
Blend of surfactants and proteins.

Indications: Seborrheic dermatitis of the scalp.

Contraindications: None mentioned.

Dosage: One lathering usually sufficient.

(Continued on page 658)



Doctor, take a second look....

BY SANDRA BREDTHAUER, CMA/ELGIN

Doctor, take a second look at the medical assistant who is working in your office. If someone were to ask you about her performance as an assistant, your first answers would be that she is conscientious, friendly and kind to the patients, tolerates your idiosyncrasies, is neat and clean in appearance, and because you seem to have no problems, you believe she is running your office at top rate efficiency.

But, doctor, why don't you investigate further. Does she belong to the Illinois Medical Assistants Association? If so, and provided she attends their meetings regularly and reads the educational material she receives as a member, you are indeed lucky. Your practice is benefiting from her up-to-date knowledge.

If she happens to be one of the 370 assistants in the United States who have studied, prepared themselves thoroughly, and successfully passed the certification examination you are doubly lucky. Of these 370 certified medical assistants, 129 are certified in administrative, 142 in clinical, and 99 dually (both administrative and clinical). Also, of these 370, only 22 are located in Illinois. Of these 22, four have administrative certificates, 11 have clinical and seven have dual certificates.

Twenty-two is a very small number of certified medical assistants for the number

of assistants working in the profession in our state.

First, doctor, if you reached a stumbling block in the second paragraph of this article by having to answer "no" to the question asked, you are in trouble. Your assistant may be doing a good job on the surface but does she really understand everything she is doing? Does she keep up with the rapidly changing environment and demands of the medical profession? Does she perform each aspect of her job in the most efficient way? Answer these questions truthfully and if she doesn't, encourage her to join our organization. She won't regret it and neither will you. Her knowledge, acquired from the educational meetings, seminars and publications sent to her, will reflect on her performance in the office, and also in the efficiency with which you can perform your duties as a very active physician.

If she is already an active member in our organization, encourage her to study for certification. Perhaps even help her and her county medical assistants chapter set up study groups not only with the goal of certification in mind but simply for the benefits of additional knowledge earned by such study groups.

If you are interested in membership in this organization for your assistant, please contact the President, Miss Ina Yenerich, 366 Hubbard Street, Elgin, Illinois 60120.

Why Get Involved?

"Some have said that it is not the business of private men to meddle with government . . . to say that (they) have nothing to do with government is to say that private men have nothing to do with their own happiness or misery; that people ought not to concern themselves whether they be naked or clothed, fed or starved, deceived or instructed, protected or destroyed."—Cato

Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

Subsequent to the listings over the past 30 months, the following list of openings for associates in general practice is furnished. These pertain to downstate. Previous listings related to Cook County. This will be continued next month.

MASSAC COUNTY: Metropolis; population: 7500. Trade area: 20,000. Need for an associate, preferably one with some experience in surgery; under age 50. Salary or percentage basis could be arranged. Opportunity for partnership after 2 years. Office available. Five other physicians in community. Massac Memorial Hospital, 65 beds; 1/2 mile from office. Industry and agriculture. Six major industries. Grade and high schools. Nearby churches. Ten miles to the junior college. Nearby golf course. For further information contact: E. T. Yap, M.D., 510 W. Tenth, Metropolis.

MONROE COUNTY: Columbia, population: 5000. Trade area: 10,000. Suburban St. Louis. Need of an associate due to large volume of practice. Salary: \$1500 monthly. Opportunity for partnership after one year. New building for 2 physicians. Three additional physicians in town. Nearest hospitals in East St. Louis, 13 miles and Red Bud, 23 miles. Many residents employed in St. Louis. Nearby churches. Grade and high schools. Twelve miles from St. Louis. For further information contact: F. W. Gebhardt, M.D., Box 110, Columbia. Phone: 281-4111.

RANDOLPH COUNTY: Chester; population: 5280. Opportunity for partnership after one year. Salary: \$20,000. Written contract. Large one story building adequately equipped. Fifty-four bed hospital, six blocks from office. Illinois State Prison here. Several small industries. Six Protestant and Catholic churches. Grade and high schools. Golf course one mile. Seventy-five miles from St. Louis. For further information contact: I. D. Newmark, M.D., and Milton Zemlyn, M.D., at 1101 George Street, Chester. Phone: 826-2388.

STEPHENSON COUNTY: Freeport; population: 10,000. Need of an associate due to heavy case load. No investment necessary. Opportunity for partnership after one year. New two-man office in shopping center. Thirty physicians in community. Freeport Memorial Hospital, 250 beds. Three blocks from office. Industry and agriculture. Protestant and Catholic churches. Grade and high schools. Highland Community College. Two public golf courses; one country club. Fine park system. County theater and concert series. For further information contact: James McGath, M.D. Phone: 233-3166 or 232-2763.

TAZEWELL COUNTY: Pekin; population: 30,000. Position available immediately due to death of former associate. Salary to start; guaranteed income. Pekin Memorial Hospital, one mile from office. Agricultural and industrial area. Protestant and Catholic churches. Bradley University, seven miles. Excellent recreational facilities. Country clubs and parks. For further information contact: V. G. Baysinger, M.D., 360 Elizabeth, Pekin. Phone: 346-3103.

WASHINGTON COUNTY: Irvington; population: 450. Trade area: 20,000. Need of an associate due to large volume of practice. Salary open. Opportunity for partnership after one year. Well equipped office. Nearest hospital at Centralia, seven miles. Second hospital at Nashville. Agricultural and industrial area. Grade and high schools. Junior College within 70 miles. Two nearby golf courses. Twenty miles from Carlyle Lake. Population of Centralia: 16,000. Lab equipped to do routine lab T4, blood gases and electrophoresis. For further information contact: Jerry I. Beguelin, M.D., Irvington.

Sustaining

The Mood

To Diet

The Clinician's Role

BY FRANK L. BIGSBY, M.D./CHICAGO

Physicians concerned with the medical management of obesity must have a thorough knowledge of abnormal human physiology, psychology, and metabolism. There must be an awareness of coexisting diseases such as diabetes and heart disease. The physician is the one individual prepared to treat *people* rather than fat. Despite this, care of the obese patient has tended to range from outright refusal to help that may be accompanied by the advice to "push yourself away from the table," health clubs and other for-profit reducing organizations, to schemes whereby the patient exerts little or no effort and relies on oral or parenteral prescriptions. A deluge of plans have resulted, all designed to treat *weight* instead of people.

In treating the overweight, the intelligent use of anorexigenic medication is perhaps the most valid supportive measure available. It is conceded that the weakness of supportive measures is that there may be a total loss of effectiveness of medication within a four to six week period. This is particularly true when the dietary program is offhandedly presented, when both

physician and patient rely solely on medication for results. With inevitable loss of drug potentiality, a weight plateau is soon reached. The alternatives have been escalation of dosage to dangerous levels, or premature cessation of the program by the disgruntled patient. To effectively overcome this weakness, the physician should initiate a long-term dietary regimen and then employ every healthful and ethical means available to prevent the patient from discontinuing. This is accomplished by establishing and maintaining rapport, insight, and motivation.¹⁻² The meaningful use of aeration and ventilation, manipulative measures, and explanatory therapy are the procedures of choice.³⁻⁴ A dieting mood must be sustained indefinitely as this allows medication to support the program in a safe and controlled manner.

The patient must be taught the nature and causes of his weight problem, the mechanism whereby the condition was produced, and how and why it can persist. The regimen should help the patient achieve a realistic weight loss and to re-educate him in order that the achievement will become a permanent way of life.

Clearly, the weapons at our disposal to promote a sustained mood to diet are inadequate. A few measures serving this purpose prominently include the first interview, long-term programming, the prudent diet, inch loss versus scale weight, definitive clinical syndromes, absolute control of supportive medication, and physician interest.

The First Interview

The patient's first visit to the physician's office is often the most important event during the entire course of therapy. The subsequent success or failure of the regimen may be decided at the initial interview. Aeration and ventilation actually begins the moment the first interview starts, and it is important that the patient be impressed by the manner in which his individual problem is being handled. Rapport has its early inception at this time.

Recording the medical history gives the patient the opportunity to unburden himself—to ventilate—as he talks freely about his condition. The release of disturbing tensions by simple mental catharsis frequently affords a direct and effective method of alleviating the psychological burden

that being fat implies. This permits the patient to gain insight into the nature of his feelings and to exercise more mature judgment in adjusting to them.⁵

The first interview should include a brief explanation of the philosophy, method, and objectives of the treatment. This should be followed by a tentative appraisal of the duration of possible changes for better or worse in the course of therapy, including the almost inevitable relapses that will occur.

It is of paramount importance for future management to outline all issues clearly at the initial interview. Should subsequent visits reveal beclouding of an issue, the physician must recall the initial outline for the patient's benefit.

Long-Term Programming

A discussion of the long-term program to be followed should be inaugurated without delay. This may be an invaluable asset in keeping the patient in a permanent dieting frame of mind. The patient must admit that intractable obesity is extant and that professional supervision for years to come may be required. This admission may be favorably compared in importance to the alcoholic's final realization that he cannot manage alcohol. Care should be exercised to define the term 'constant supervision.' The interminable reliance on the various reducing aids is not to be implied. Contrariwise, the ultimate objective entails acquiring the ability to control caloric intake independent of outside influence. In difficult cases this is accomplished by gradual withdrawal of supportive medication, and the substitution of what has been termed "constructive state of physician dependency"⁶ once optimal individual weight is achieved. At an opportune time the interval between office visits may gradually be lengthened with the eventual goal being sufficient consultations to fix the weight and figure at a desirable level. Should the constructive physician-patient relationship

be adequate to control weight for several years there is hope for stabilization. By following the definite program outlined there is evidence to support the belief that the emotional outlook toward food may be permanently altered for the better. Other benefits may be derived from this prolonged therapeutic approach. Not the least important is the improved attitude the patient may develop following the admission of the presence of intractable obesity. Although the sudden discontinuance of treatment is to be decried, if this should come about, the patient will not hesitate to again consult his physician because of a feeling of guilt. He need not swallow his pride and force himself to re-establish therapy; more often he may anxiously return for continued supervision.⁷

The Prudent Diet

Explaining long-term prudent dieting⁸ is deceptively difficult. When manipulative measures are successful in this area a *giant step toward sustaining the mood to diet indefinitely is accomplished.*

To counter the natural tendency for spectacular weight reduction through "crash-dieting," the physician should refuse to discuss any goal but gradual loss over months and years. It should be explained that an average weight loss of over five pounds per month is not suggested. Since this is an average, the patient need not be too discouraged if but two pounds are lost in certain months. Patients should be impressed with the fact that the long-term downward trend has the only really important influence on health. To focus attention on the long-term view, they should be urged not to weigh themselves at home; the weight should be recorded at the physician's office only.⁴

The prudent diet for gradual weight loss need not be extreme; many patients will lose weight eating as much as 1,300 or 1,400 calories daily. Before giving specific instruction, a clear idea of past activities should be obtained. Those who have been tampering with their diets for many years may develop extraordinary eating habits as they move from fad to fad. In these instances specific diets limiting caloric intake and insuring good nutrition are called for. Meals should not be skipped; slow mastication may help achieve a sensation of full-

Frank L. Bigsby, M.D., is a Chicago general practitioner. A graduate of the Tulane University, School of Medicine, he possesses a special interest in the clinical management of obesity.

ness after eating less. Caloric balance may be restored by allowing some fats and by insisting on a high protein, limited carbohydrate intake. Between-meal snacking should be discouraged. For those who find this unbearable, snacks of protein only are suggested, but no crackers or bread allowed. This concept is within keeping with diets suggesting frequent small feedings rather than three large meals. Fluids should be restricted to eight glasses per day, unless otherwise contraindicated.⁹

As many of the patient's favorite foods as possible should be included in his personalized diet. It is wise to avoid unreasonable caloric demands that necessitate two separate menus for the family. Last minute substitutions should be provided when the patient dines out.

The object of this program of caloric reeducation is obvious. The diet is not meant to be a temporary measure but the basis for future eating habits. Most people lose weight satisfactorily on this regimen. A plateau somewhat above the ideal weight may ultimately be reached. The caloric requirements and supply must then be determined and a diet having an accurately prescribed caloric content inaugurated.

A gross estimate of total calories needed to maintain the present static weight of a sedentary or moderately active adult may be achieved by multiplying this weight by 12 calories per pound. Thus a man leading a sedentary or moderately active life and weighing 175 pounds may need 2,100 calories to maintain his weight.

A second method of estimating total caloric requirement in instances of static weight may be accomplished by observing body weight over an extended period of time while the patient keeps an accurate food diary; the long-term program designed to improve rapport and insight insures patient reliability.

A deficit of 500 calories per day under maintenance needs allows a loss of about one pound of fat per week. In a given individual, final selection of total calories for weight reduction will be arrived at by trial, with an increase in calories if the person is losing too rapidly and a decrease if too slowly.

It is difficult to envision a better illustration of treating *people* rather than

weight in the medical management of obesity.

Inch Loss Versus Scale Weight

Theoretically, a person placed on a reducing diet should lose weight immediately. It is difficult to realize that humans *can* exist on severe caloric restriction for a prolonged period and still show no weight loss. This is related to body water balance. During the early days of a diet when body fat and protein are being burned, water is released; it should be pointed out that when the body burns 100 grams of fat, 112 grams of water is produced—more water weight than the fat that was burned. It is estimated that approximately one-half of body fat is stored in subcutaneous tissues. Consequently, any appreciable loss of adipose tissue will reflect in less body measurement. If the fluid in this metabolic process is not immediately expelled by the kidneys, the intestines, and through breathing it is retained in connective tissue, thus the loss in measurement with static weight.

An additional feature involving kidney function in obese people is an exaggeration of the normal postural effect. Less water elimination by the kidney in the standing position, and more elimination in the lying position, has been known for many years and is normal. In obese individuals, the influence of body position may be considerably greater and changes in importance from one person to another. Almost complete stoppage of urine formation in the erect position is seen in some obese people.

The problem of fluid retention in obesity is almost invariably more severe in females. This sex difference does not entirely depend on the presence of female hormone since it is a troublesome finding in women after menopause. In young women, the problem is always aggravated during premenstrual week and usually is slightly relieved after the flow begins.⁹

A pragmatic explanation of the modus operandi of inch loss sans weight loss prevents many individuals from prematurely breaking off their diet because it affords a sense of accomplishment. When associated with dieting and water release, the appearance of rather severe ankle edema is visible proof stored fat is being metabolized. The demonstrable edema resulting

from this metabolic phenomenon constitutes the only true indication for the guarded use of diuretics in a reducing regimen.

These remarks make up an excellent example of explanatory therapy and show how a knowledge of human metabolism is vital in the medical management of obese people.

Definitive Clinical Syndromes

The obese individual will quickly recognize whether the physician understands his needs and attitudes: that is, his need to preserve his self respect which is expressed as anger, hostility, defiance or a "superior attitude;" his fear, which is expressed as insecurity, anxiety and the various means used to cover up fear, and his need for dependence and love.⁴

While our present limited knowledge of obesity makes definitive classification difficult to achieve, it is nonetheless of great clinical importance to attain a suitable working understanding of the various clinical syndromes extant. This will serve many useful purposes, including the patient's ability to understand the problems confronting him and the knowledge that therapy can be applied on a personal basis. There may be no better method of displaying concern for the patient and thus sustaining the mood to diet.¹⁰

Limited space prevents a discussion of each obese syndrome. A few components contributing to weight fluctuation include: genetic factors; personality changes, energy expenditure; occupational and environmental stimuli; ethnic influence; status of motivation, insight and rapport; emotional and physiological tension states; prognosis for weight loss; and metabolic changes accompanying advancing years.

Human behaviour is influenced by these manifold factors, fat storage cells are not. The wide assortment of anti-obesity programs, scientific or pseudoscientific, is difficult to justify in the light of these considerations.

Absolute Control of Supportive Medication

We have seen that the prime goal in managing the obese patient is to improve motivation, establish rapport, and afford information that may improve the patient's insight. Without question, insight

will be impaired by placing too much stress on anorexiant, "water pills," metabolic stimulants, endocrine substances allegedly designed to correct glandular imbalance or to "break down fat." In such instances an attachment for medication may be established and will remain only for as long as results are obtained. A true test of proper rapport and insight is the patient's acceptance of candid explanation of the nature of the lack of results in reducing and refrain from prematurely discontinuing treatment.

Absolute control of supportive medicine should be assumed. The obese patient needs regimentation of caloric habits as well as in other areas; absolute control of supportive medication induces regular office visits providing opportunity for the physician to apply the principles of aeration and ventilation, manipulative measures, and explanatory therapy. These principles cannot be practiced by remote control. Control of medication eliminates the danger of drug habituation prevalent in immature obese people by employing look-alike prescriptions of varying dosages and matching placebos. Regular office consultations afford the opportunity to frequently change the type and potency of medication and psychological dependence on the formulas can be better controlled.⁴


Physician Interest

Based on the statements in this paper, it is obvious that special knowledge, time, interest, and proper personnel are required if the physician is to assume his proper role in sustaining the mood to diet. ◀

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(Continued on page 656)



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SOCIO ECONOMIC *news*

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BY JOSEPH J. LOTHARIUS

Some Thaw In Medicare Fee Freeze Promised

Many Illinois physicians may have their 1969, fee schedules recognized by Medicare after July 1, 1970, if the legislation recommended by HEW is approved as expected. Continental Casualty Company (Part B Medicare carrier for 97 Illinois counties) told ISMS the Bureau of Health Insurance has issued a new regulation permitting carriers to revise their customary and prevailing fee ceilings. Under the new regulation, fee ceilings will be calculated on a frequency of service basis. This could raise prevailing fee ceilings and recognize the MD's fee increases made during 1969, a period when Medicare fee ceilings were frozen. The BHI regulation pointed out that all revisions will be based on charge data compiled from 1969, statistics. Only those carriers who can identify a physician's customary charge for a particular service, and can calculate the prevailing charge for a procedure in a specific area, can participate under the new regulation.

Health Insurance Carriers Speak Many Languages

The adoption by private and governmental health insurance carriers of a standardized system for coding diagnosis and treatment is apparently not on the immediate horizon. AMA's new edition of *Current Procedural Terminology* (CPT), is the latest effort to entice national conformity by all users. However, this new five-digit system patterned after the California Relative Value Studies prepared by California Medical Association, will only be used by one governmental carrier in Illinois. Only Medicaid—administered by the Illinois Department of Public Aid—has announced it would adopt CPT later this year. The state's two Medicare (Part B) carriers, Blue Shield and Continental Casualty Company, are using a four-digit nomenclature system, and an earlier version of the California RVS respectively. The regional office of the Bureau of Health Insurance in Chicago said the subject of standardization was to be discussed at a national meeting in Baltimore. The BHI office said, however, it had no word from the Social Security Administration about any moves toward conformity. Meanwhile, the inefficient and costly variety of coding systems by carriers throughout the country continues.

Fee-for-Service Desirable; Even In Group Plans

Elimination of fee-for-service in prepaid group plans has created a new set of problems, according to a report appearing in *Scientific American* by Dr. Sidney R. Garfield, founder of the Kaiser-Permanente plan. Dr. Garfield says fee elimination is a barrier to early entry into sick care because, "when we removed the fee, we removed the regulator of flow into the system. The result is an uncontrolled flood of well, worried-well, early-sick and sick people into our point of entry—the doctor's appointment—on a first-come, first-served basis. This overloads the system and the usurping of doctor's time by health people actually interferes with the care of the sick." A possible solution, according to Dr. Garfield, is a new regulator called multiphasic screening or health testing.

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ISMS Delegates Call For Investigation of DVR

A recommendation calling for an investigation of the Illinois Department of Vocational Rehabilitation was approved by the ISMS House of Delegates during the 1970 convention. The recommendation asked that the current DVR program in the state be investigated to determine the possibility of over-utilization of the program, and the qualifications for eligibility to it. The ISMS request was to be submitted to the Illinois Advisory Committee on Medical Costs and Utilization of Services (Created by Senate Bill 1139, enacted by the 76th Illinois General Assembly).

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Rate Negotiation For Hospitals Asked

In an effort to stem spiraling health care costs, ISMS Delegates endorsed a resolution calling for prospective rate negotiation as the method of hospital reimbursement. The resolution charged that retroactive cost determination for hospital payments by Medicare, Medicaid and Blue Cross does not create sufficient motivation for hospitals to control costs, since full reimbursement is guaranteed. Delegates also asked that this resolution be submitted to the AMA House of Delegates.

Cigarette Smoking Linked to Hearing Loss

An investigator from the Women's Medical College of Pennsylvania reports that cigarette smoking may be linked to a mildly impaired ability to hear low-pitched sounds. According to William Weiss, M.D., a visiting associate professor of preventive medicine at the Women's Medical College, a study of 97 male executives revealed that 35% of the 65 cigarette smokers had a hearing loss of 15 decibels or more at a pure tone frequency of 500 cycles per second. Forty-one per cent of the 48 men who smoke a pack or more per day suffered a similar loss at these low-frequency tones. In contrast, the disability of 15 decibels or more could be found in only 19% of the 20 non-smoking executives in the series. (The number of cigar and/or pipe smokers was too small to analyze.

According to Dr. Weiss, the findings from the study "are consistent with the hypothesis that cigarette smoking causes a conductive hearing loss, probably due to involvement of the eustachian tube, in some individuals. (Cigarette Smoking May Cause Small Hearing Loss, *JAMA* (Dec.) 1969.)

President's Page

(Continued on page 584)

poor . . . the absence of doctors in the ghettos and villages . . . the infant mortality rate . . . the cost-of-health figures. Tune into television networks, and you learn the miracle cure for all these problems: compulsory government medicine.

Generally, how should we physicians react? With plethoric rage? With a contemptuous shrug of the shoulders? With escapist retreat behind our office doors?

No, there is a positive position we can and must take. Each of us owes this responsibility to our profession. And I, as your President in the coming year, will uphold this responsibility.

We must tell the people of Illinois what we can do, beyond what we have done. But first we must convince ourselves of what we can do.

We have done much—and can do more—to make health-care more abundant for our medically deprived communities . . . for young children . . . for victims of disease and social misfortune. Voluntarily, we can make health care more economical.

Group Practice

A major challenge is the increasing shortage of physicians in many parts of our state.

In 1967, according to a nationwide AMA survey, less than 15% of the physicians in private practice were in non-metropolitan areas. One may argue: "That's not so bad—only 30% of the population still lives in such areas." I say the proportion is bad. The lack of doctors in the countryside and small towns must be multiplied by distance—the miles that must be traveled for help when accidents or serious illness strikes . . . the long, discouraging journey to get the routine care that cities and suburbs take for granted.

When the older physicians retire, the rural shortage will worsen. The trend is reflected in our ISMS records. Twenty years ago our Placement Service would list about 200 M.D.'s seeking a location and about 20 locations seeking a doctor. Today the situation is reversed—about 200 towns are crying for doctors . . . only about 15 to 20 men, mostly unqualified, are applicants.

That, roughly, is the situation. What are we going to do about it?

I urge that we consider the encouragement of group practice. Older doctors could perpetuate their practice through a group plan. New doctors could be attracted by one, regardless of how remote the location.

Group practice can put many types of medical disciplines under one roof in a period when an overwhelming majority of medical school graduates are specialized. A multi-disciplinary arrangement not only gives the specialist the opportunity he wants; it gives the patient the variety of services he needs.

Such practice can reasonably assure a steady income and fringe benefits, without heavy individual investment. It can enable its members to buy the best available equipment for administrative functions, diagnosis, therapy and research. It can computerize record-keeping, so that case histories are in one orderly file, regardless of how many member doctors are seen by the patient. Through joint use of administrative and paramedical personnel, group practice can free the doctor from book-keeping . . . from direct monetary entanglements with patients . . . from heavy overhead. Through collective scheduling, it can regularize the working hours of the doctor, yet assure the patient of emergency service at any hour. The doctor will have time for scientific meetings, continuing education courses and vacations.

Working together, the physicians can improve each other's professional excellence. And in the small town context, they can give one another companionship.

Of course, there are obvious disadvantages too. There may be some sacrifice of independence and personalized patient relationships. There may be too great a tendency to confine referrals within the group.

Right after World War II, there were only 400 group practices in the United States. In 1959, there were 1,546, with 13,000 participating physicians. By 1965, the number had grown to 4,300, with 28,380 doctors. Six short years had produced a 65% increase in groups . . . a 200% increase in participants.

Group practices may enjoy the privileges of a corporate structure, partnership, association or foundation. Here in Illinois the General Assembly in 1963 passed a law permitting corporations of physicians. These—after a round of fights in the courts

—now are recognized for U. S. tax purposes.

Seven hundred and thirty medical corporate charters have been issued in our state since the 1963, law—about 550 or 75% of them within the past year.

Let's carry the statistics, for a moment into everyday life. Let's go to Olney in southeast Illinois. That town of 9,000 is 35 miles from a railroad track. The closest familiar town is Vincennes, across the Indiana line. Olney, in short, could have been a typical candidate for medical deprivation. But it has a thriving multi-disciplinary clinic with more than 20 physicians. That's the Olney story. It could be the story of many small communities.

Group practices can serve not only their home town but a wide radius. Satellite offices could be set up in towns nearby. These could be visited periodically by a doctor from the central clinic—and manned at other times by a specially trained nurse or medical corpsman. A similar arrangement has provided emergency care in many industrial plants for years.

Some of our critics insinuate that organized medicine is opposed to group practice. Let them scan the proceedings of the AMA House of Delegates over the years, and find one evidence of hostility. As a matter of fact, the AMA House resolved in 1959, that group practice is "within the limits of ethical propriety, provided ownership and management remain in the hands of licensed physicians."

The Himler Report of the AMA Committee on Planning and Development, is even more liberal . . . drastically so. It advises the AMA to "take no public position for or against private solo practice, private group practice, closed-panel group practice, fee for service payment or prepayment by capitation."

A minority of the committee has dissented, stating that "private practice should not be disparaged nor its support abandoned." Its report acknowledges, though, that "other systems of practice are in some circumstances acceptable, appropriate, advisable or even necessary."

Some of you may object—and with reason—to group practices that are not medically owned or that depend on capitation payments. But within reasonable bounds we can stimulate the expansion of group plans.

Every family doctor enjoys the affection and respect accorded him by his people. Neither he nor they like to think of the time when he no longer will be able to care for them. In times past young doctors would take over, but now young family doctors cannot be found. As trustworthy guardians of the health of their patients, any and all doctors, on reflection, will embrace whatever system will insure quality care in the future for those who have honored them. It is our moral responsibility to provide for the many others in the state that even now do not have adequate medical care.

To younger physicians we can say: A multi-disciplinary group practice in a smaller community will offer you all the professional advantages—plus some special ones. You quickly will become an honored figure in your community. You will be helping the medically desperate, and they will be grateful.

Pre-School Examinations

Along with small towns, we want to do more for small people—the children.

Members of your county medical societies already are donating thousands of hours to centralized programs of immunization, examination and screening for school-age children.

ISMS has been surveying the societies to find out exactly how much free service is being given—and what it means in dollar value. I know that in Logan County alone, the doctors volunteered 250 hours this past year. Translate those hours and services into the equivalent charges for office visits—and then count the savings and blessings for the children served. In behalf of ISMS, I commend this generosity.

Thousands of these children were from indigent families. Some, from infancy, have suffered physical and emotional disorders that were neglected. Detection in the first few years of life could have brought cures and hope. But the state law on immunization and examination does not reach the children until they approach the first grade.

Accordingly, Harold O. Swank, director of the Illinois Department of Public Aid, has sounded a challenge. In our *Illinois Medical Journal* he has called for "extending the examination and immunization

programs to children from birth to entrance in school."

The facts and figures prove his point.

Between last New Year's Day and April 24, Illinois was hit by an epidemic of measles—1,742 cases, or 10 times the same period total for 1969. Most of the victims were poverty-stricken children, aged 3 to 5. All could have been spared from measles had they been immunized.

Through Project Head Start, some 32,000 children—aged 3½ to 5—were given visual screening last year. Ailments—primarily ambliopia—turned up in 974 of them, or 3%. Now what if 500,000 had been screened? Using the 3% ratio, 15,000 of them would be able to see more clearly in school—and in life.

In the last half of 1969, a state program found hearing defects in 23 of 1,400 school children. If tests were given to 500,000 youngsters aged 3½ to 5, perhaps 8,000 cases of faulty hearing would be uncovered in time for proper treatment.

Chicago's Children and Family Project—headed by Dr. Edward Murray—gives clinical attention to 40,000 children from the three lowest-income neighborhoods. Caring for the child from early infancy, the project has remedied such ills as rubella, eye defects, hernia and respiratory ailments. Its preventive medicine has curbed hospital admissions, Dr. Murray notes.

The project cooperates with the Board of Health in blood-testing 100,000 children a year for lead poisoning . . . and keeps symptomatic cases from becoming disastrous.

The Children and Family Project gets federal support. Think how much it, and other community and state projects, could achieve with additional funding.

That's the situation. What can we do about it?

Legislatively, of course, we can urge full support for these ventures. But we also can do plenty at the grassroots, and in those city neighborhoods that have no grass. Through our county medical societies, we can expand our wonderful voluntary service for school-age children, and give examinations and immunizations to those of pre-school age.

Consumer Education

There are other areas in which we can share the concern of welfare officials.

Much has been said about hunger among the poor. While its extent is debatable, we do know that malnutrition is widespread. The problem is not just eating enough but eating wisely . . . not just food allowances but food knowledge. Ambitious programs of consumer education exist in Chicago and Cook County; IDPA case-workers around the state carry its principles to welfare recipients. But serious gaps persist.

Drawing on our insight into the link between diet and health, we of ISMS can ponder ways to broaden consumer education. For example, we can prepare pamphlets to be distributed through doctors . . . and a series of public-service programs for radio.

Abortion

Abortion is another controversial topic linked to medicine. Acting along the lines of the AMA House of Delegates, we have called for modification of the Illinois abortion law. Our State Legislature is taking longer than we did to reach a position—but liberalization, I feel, is only a matter of time.

Changes in the law could raise some side-issues. A problem will be posed by indigent mothers qualifying for therapeutic abortion. Their cases—unless properly handled—can mean special tragedy for mother, child and society.

I suggest that ISMS, other health-care providers and government authorities, give thought to free abortions in indigent cases. I further suggest that we cooperate in spreading the knowledge of birth control on a medically and ethically sound basis. The "Pill" controversy is merely the most dramatic example of the confusion that prevails in this matter. Confusion and lack of understanding can be particularly pitiful among the poor and uneducated.

In review this year I plan to stress four major areas:

First we plan to urge the establishment of facilities to keep all members up-to-date in our professional knowledge through continuing education.

Second, through Peer Review we hope to set up an efficient system to adjudicate

disputes between doctors and others.

Thirdly, we must protect each other from fraudulent malpractice claims hoping thereby to discourage the filing of such suits. I would urge this to be done through a screening committee which will recognize and admit legitimate claims, but which will also provide for expert testimony for those wrongly accused.

Fourthly, we must find ways to increase the quantity of medical care without sacrificing quality. This can best be done by embracing the efficient techniques of business which would relieve the physician of trivia and let him concentrate on significant problems. These of necessity would be usable only when a number of doctors work together.

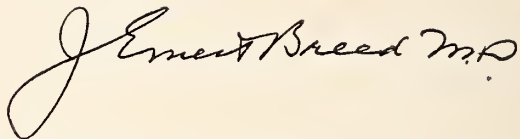
Epilogue

In essence my aspiration for the year ahead revolves around one question. Not "What is happening to us?", but "How can we make things happen?"

Certainly these sullen, insistent times are flinging a gauntlet at us. Certainly they give us cause for uneasiness and alarm.

But the greatest thing we have to fear is our own inaction.

Fellow members of Illinois State Medical Society! I offer you—and seek with you—a year of action!



Cancer "Gun" Utilized

An implantation "gun" which "shoots" radioactive chromium into cancer tumors, destroying them without harming normal body tissue, is being used by physicians at The University of Chicago. The project is one of several being carried out by Dr. Melvin L. Griem, Associate Professor of Radiology; Dr. Paul V. Harper, Jr., Professor of Surgery, and their associates.

The procedure is conducted in the Argonne Cancer Research Hospital, which is operated by the University for the U.S. Atomic Energy Commission.

Results thus far have been "quite encouraging," according to Dr. Griem. Of 25 patients receiving the treatment, 18 have shown "good" or "favorable" responses. One patient who received the treatment 7-1/2 years ago, today is leading a normal life. At the time of treatment, the patient had a life expectancy of six months.

The chromium seeds used are prepared from special high-purity wire made by the U.S. Bureau of Mines. Bureau scientists had first prepared the high-purity chromium to investigate its metallurgical properties. Cancer investigators learned about the material and requested supplies for research.

Since the metal must be exposed to radiation in a nuclear reactor to convert it to a radioactive isotope called chromium-51, high purity is essential. Any impurities would also become radioactive and subject a patient to undesirable radiation.

"The type of radiation given off by

chromium-51 is highly desirable for cancer implants because the radiation is not so penetrating that it would cause damage to normal tissues of the body," said Dr. Griem. "Chromium-51 has a half-life of 27 days. This is long enough to insure that the tumor receives an effective dose of radiation, but not so long that the implants would have to be removed to prevent an overdose.

"Furthermore, the chromium implants are almost completely inert in the body. There is no evidence that they are likely to cause any unfavorable reactions."

To produce the implantation seeds, hair-fine chromium wire is first cut into 3/16-inch lengths. These seeds are then irradiated in a research reactor at the Argonne National Laboratory for two or three days. The relatively long half-life of the radioactive chromium isotope allows the seeds to be kept in a sterilized lead container until needed.

Implantations, according to Dr. Griem, can frequently be made without surgery. However, in some cases, deep-seated tumors have been exposed sufficiently for implantation at the time of surgery. From three to sixty seeds have been implanted in tumors of individual patients and good results have been obtained with tumors located in a number of different parts of the body.

The implantation gun was developed specifically for clinical use and is available commercially.

Health Care

BY JACK L. GIBBS, M.D./CANTON

in the
70's

Discussion of health care for the future must include a look at what we now have and what we had in the past. About ten years ago I began to be concerned about a developing rural manpower shortage and the shrinking pool of practicing physicians as a potentially serious problem. I was critical of medical education and educators for failure to be aware of community health needs, and for their lack of emphasis on programs designed to produce family physicians. During these ten years, I have been increasingly involved with organizations concerned with the problems of medical education, manpower and health care delivery. This involvement has not alleviated my concern but I am now more aware of the barriers to change and the inevitable lag between the recognition of problems and their ultimate solutions. Impatience to see the change has been tempered by a recognition that there are no simplistic solutions. The problems of health care delivery are complex and subject to the vagaries of social phenomena, population shifts and political economic trends. I see what may have been a solution for that time may not be the solution for today as we continually try to adjust to the many forces and pressures of change. Nonetheless, the prognostications of the health care crisis as a result of inadequate manpower have come to pass, and its urgency has prompted action by many groups and agencies.

Where Are the Doctors?

Well, where are the doctors? First of all we must take cognizance of the national shortage of workers in most of the professions and trades. The shortage of doctors, however, is even more apparent due to the wide-spread utilization of their services and the increasingly accepted social concept that quality health care is a basic human right which should and must be available to all regardless of their ability

to pay. Our present crisis can be blamed in part on lack of planning for increasing the production of physicians to meet the needs of an expanding population. Organized medicine and medical schools will have to accept a fair share of the blame for this. But there are other factors and trends responsible for this crisis, and not all of them were foreseeable.

In the last 50 years medicine's scientific and research orientation has resulted in a fantastic knowledge explosion. The outcome has been the fragmentation of health care delivery which became disease, system and organ oriented instead of patient oriented. A massive shift to specialization with its special challenge and status has been a natural consequence. All of the specialists need hospital facilities and some need complex equipment. Many must practice in high density population areas to draw enough patients with problems peculiar to their specialties. These things in turn lead to a greater institutionalization of care in urban centers. At the same time it leads to further physician shortage because it takes more physicians to take care of that one patient

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although important to the patient's total care, are unrelated to the care of his routine medical problems. One-third of all physicians now devote their time to research, industry, teaching, administration and public health, all functions of importance but not directly related to patient care.

The armed forces have also taken their toll on our force of practicing physicians. As a consequence of these trends the number of M.D.s caring for private patients declined 10% between 1950 and 1965, and the general care physicians which include internists, pediatricians and general practitioners declined by 35%.

Health Services Burdened

In addition to the relative decline in practicing physicians and the developing imbalance between consultants and family practitioners, there has been a tremendous increase in the utilization of health services. In my opinion, the two major factors responsible for this increased utilization are an increase in health consciousness and the increase in health care purchasing power. By health consciousness I mean the increasing public awareness of the importance of early diagnosis and treatment, and the increasing awareness of the effectiveness of medical care which prompts them to seek care sooner and more frequently. In fact, this has led to an over-utilization of physicians and the expectations of the public outstrip the ability of the physicians to produce, both in quantity of service and in scope of cures. The emphasis on preventive medicine has prompted a long list of required examinations by schools, employers, industry and government, a trend which although theoretically laudable imposes a tremendous burden on the present health care delivery system. I say theoretically laudable because examination of asymptomatic people has been disappointing as a mechanism for improving health.

As society becomes increasingly affluent and as increasing amounts of health care costs are paid by third parties, the ability to pay is no longer a barrier to the utilization of services. Where care is truly needed this barrier should not exist but there is no doubt that its removal has added an enormous burden of sick and not-so-sick people to the already overcrowded offices and hospitals. The proliferation of government programs with the attendant increase in

health care purchasing power has been a big factor in aggravating existing shortages of manpower and facilities. At a time when changes in the practice of medicine are resulting in a relative decrease in manpower, we have had a concomitant explosion in the need for and utilization of health care services.

What then can we look for in the decade to come? How do we solve this crisis which increases daily in its proportions? I cannot supply the answers to these questions but I can advise you of some of the efforts being made and the directions that they take. I would also like to relate this to your own community and what you can do to help us solve it.

What's Being Done

The problem is being attacked on many fronts by government, by medical schools and educators, by the consumers, and by the medical profession itself. In addition to the AMA and State Society Councils on Education and Manpower, there has been a special Medical Society Task Force working on manpower problems. There have also been numerous groups, including health consumers commissioned by the government, to study the problem in depth. As one might expect there is no unanimous opinion regarding solutions to the problem. Most agree, however, that regardless of what else we do, we must graduate an increasing number of physicians. In line with the recognition of this need our State Medical School has plans for doubling its output of graduates by 1978. Two new medical schools, Rush Medical College and Southern Illinois University Medical School, will admit students in 1971, and 1972. As a result of state supported financial incentives to private schools for increasing enrollment of Illinois students, a sizable increase in class size by each medical school is anticipated in 1970. The overall effect is an increase in medical students by 1975, from the present 2600 to 4800, an increase of 2200 students. Even this healthy increase, however, will not meet our needs in the face of the predictions of increases in population and utilization of health services.

Many investigators of our present manpower crisis, among them the Citizens' Commission on Graduate Education, commissioned by the American Medical Association, believe we must restore the balance between specialists and family physicians. They

recommend that the medical school design programs to encourage production of family or primary care physicians. They stress that the consumers of health care are desirous of such a health care provider and he is the logical person to provide comprehensive personal and family health care in the patient's own community. In our own state the legislature has ruled that all medical schools supported by state funds must develop a Department of Family Practice. It is encouraging to see the private medical schools moving in this same direction as they recognize the importance of such an individual in the health care scheme. There are several road blocks to such a solution however, not the least of which is the apparent unwillingness of recent graduates to enter solo practice and to settle in smaller communities. The professional and cultural isolation which he and his wife envisage in a small community is the major deterrent to such a move. The other major road block, to the advancement of the primary physician as a solution to the health manpower crisis, is the feeling of many government planners and some medical educators that moves in this direction are against the main stream of evolving patterns of care.

These evolving patterns include further specialization and super-specialization with regionalization and centralization of health care resources, facilities and personnel. This would tend to increase the institutionalization and urbanization of care with formation of group practices of either single or multi-specialty representation. It is also the hope of many of these planners that such a system of health care will lead to the nationwide standardization and regulation of health care costs through development of prepaid plans which would replace the present fee for service concept of payment for health care. Those who favor such a system of health care believe that presently evolving patterns should be encouraged. The ultimate goal would be provision of care by regionalized multi-specialty clinics and hospitals providing health care on a prepaid basis.

I am sure that the 70's will see experimentation in many types of health care delivery systems and I hope that we can be flexible in working toward our ultimate goal of provision of health care for all the people of our country. On the other hand, if the thrust is only in the promotion of prepaid

group practice we can expect an aggravation of the manpower crisis and increasingly impersonal and costly methods of health care delivery. It has become fashionable for government planners and others to criticize what they call our non-system of health care. They say it is episodic and disease oriented rather than preventive medicine oriented. They suggest that group practice will in some way result in more care for more people and that it will be less expensive. I take issue with such unproven and ill-founded statements that are passed off as facts on the American public. Today's medicine is, as a matter of fact, so preventive oriented that we can't see the sick. Office schedules are so crowded with checkups, school physicals and the like that the patient with an acute problem often cannot be seen. One can spend the whole busy day without seeing an ill person. The implication by some that preventive medicine will see the end of disease oriented or episodic medicine is illusory and until the manpower crisis is solved the checkups might have to wait while we treat the sick. Preventive medicine, however, is an area where I believe manpower sparing is possible and yet let us achieve the desirable goals of decreasing the incidence of disease and spotting it early in its course. It is here that the use of computer technology, multiphasic health screening, and paramedical personnel may be of service.

The contention that group practice is desirable because it can provide more care for more people is another planners' balloon I would like to deflate. I personally have been in three practice settings, solo practice, two-man partnership, and eight-man multi-specialty group practice. For the physician, group practice affords more leisure time, assures coverage of one's patients when he is unavailable, and provides the stimulation and comfort of close peer association. Because of income from the ancillary services provided in the clinic there is little, if any, sacrifice in personal income. For the patient, on the other hand, group practice results in fewer patient visits per doctor, it tends to depersonalize the care, and it tends to be more, not less expensive as the overhead is usually higher. He does gain assurance of continuous coverage and provides the convenience of a wide spectrum of services in one setting. In view of our present social and professional cli-

(Continued on page 650)

Rx Products Index

Achrostatin	659
Lederle Laboratories	
Aventyl HCL	648-649
Eli Lilly and Company	
Cordran Tape	594
Eli Lilly and Company	
Dicarbosil	658
Arch Laboratories	
Doxidan	3rd Cover
Hoechst Pharmaceutical Co.	
Garamycin Injectable	585-588
Schering Corporation	
Isoclor	579
Amar-Stone Laboratories, Inc.	
Kantrex	577
Bristol Laboratories	
Librium	580-581
Roche Laboratories	
Neosporin Ointment	576
Burroughs Wellcome & Co.	
Neo-Synephrine	574
Winthrop Laboratories	
Obedrin-LA715L	593
Semed Pharmaceutical Div., S. E. Massengill Co.	
Flagyl	2nd Cover
G. D. Searle & Co.	
Quinamm/AVC	637, 638
National Drug Co.	
Salutensin	646-647
Bristol Laboratories	
Tepanil	583
National Drug Co.	
Thorazine	573
Smith, Kline & French Laboratories	
Valium	Back Cover
Roche Laboratories	
Vibramycin	590-592
Pfizer Laboratories, Div., Pfizer & Co.	

Brief Summary of Prescribing Information—
9-9/22/69. For complete information consult
Official Package Circular.

Indications: Essential hypertension. Use cau-
tiously in patients with renal insufficiency,
particularly if they are digitalized.

Contraindications: Anuria, oliguria, active
peptic ulceration, ulcerative colitis, severe de-
pression or hypersensitivity to its components
contraindicates the use of Salutensin.

Warnings: Small-bowel lesions (obstruction,
hemorrhage, perforation and death) have
occurred during therapy with enteric-coated
formulations containing potassium, with or
without thiazides. Such potassium formula-
tions should be used with Salutensin only
when indicated and should be discontinued
immediately if abdominal pain, distension,
nausea, vomiting or gastrointestinal bleeding
occurs. Use cautiously, and only when deemed
essential, in fertile, pregnant or lactating pa-
tients. *Use in Pregnancy:* Thiazides cross the
placenta and can cause fetal or neonatal
hyperbilirubinemia, thrombocytopenia,
altered carbohydrate metabolism and possibly
electrolyte disturbances. Fatal reactions may
occur with reserpine during electroshock
therapy; discontinue Salutensin 2 weeks be-
fore such therapy. Increased respiratory
secretions, nasal congestion, cyanosis and
anorexia may occur in infants born to reser-
pine-treated mothers.

Precautions: Azotemia, hypochloremia, hypo-
natremia, hypochloremic alkalosis and hypo-
kalemia (especially with hepatic cirrhosis
and corticosteroid therapy) may occur, par-
ticularly with pre-existing vomiting and diar-
rhea. Potassium loss or protoveratrine A may
cause digitalis intoxication. *Potassium loss
responds to potassium-rich foods, potassium
chloride or, if necessary, discontinuation of
therapy. Stop therapy if protoveratrine A
induces digitalis intoxication.* Serum am-
monia elevation may precipitate coma in
precomatose hepatic cirrhotics. Discontinue
therapy 2 weeks before surgery or if myo-
cardial irritability, progressive azotemia or
severe depression occur. Exercise caution in
patients with chronic uremia, angina pec-
toris, coronary thrombosis or extensive cere-
bral vascular disease or *bronchial asthma* and
in those with a history of peptic ulceration or
bronchial asthma; in post-sympathectomy pa-
tients; in patients on quinidine; and in pa-
tients with gallstones, in whom biliary colic
may occur. Patients who have diabetes
mellitus or who are suspected of being pre-
diabetic should be kept under close observa-
tion if treated with this agent.

Adverse Reactions: Hydroflumethiazide: Skin
rashes (including exfoliative dermatitis), skin
photosensitivity, urticaria, necrotizing angitis,
xanthopsia, granulocytopenia, aplastic
anemia, orthostatic hypotension (potentiated
with alcohol, barbiturates or narcotics), aller-
gic glomerulonephritis, acute pancreatitis,
liver involvement (intrahepatic cholestatic
jaundice), purpura plus or minus throm-
bocytopenia, hyperuricemia, hyperglycemia,
glycosuria, malaise, weakness, dizziness, fa-
tigue, paresthesias, muscle cramps, skin rash,
epigastric distress, vomiting, diarrhea and
constipation. *Reserpine:* Depression, peptic
ulceration, diarrhea, Parkinsonism, nasal stuf-
finess, dryness of the mouth, weight gain,
impotence or decreased libido, conjunctival
injection, dull sensorium, deafness, glaucoma,
uveitis, optic atrophy, and, with overdosage,
agitation, insomnia and nightmares. *Proto-
veratrine A:* Nausea, vomiting, cardiac ar-
rhythmia, prostration, blurring vision, mental
confusion, excessive hypotension and brady-
cardia. (Treat bradycardia with atropine and
hypotension with vasopressors.)

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Warnings: Use in convulsive or hypotensive states should be closely followed by the physician.

At present, data are insufficient to recommend the drug during pregnancy. The possibility of a suicidal attempt in a depressed patient should always be considered.

There have been rare reports of agranulocytosis, jaundice, hypotension, tremor, urinary retention, thrombocytopenic purpura, and paralytic ileus. Periodic laboratory studies are recommended.

Cardiovascular complications, including myocardial infarction and arrhythmias, have been reported occasionally with related drugs. Patients with cardiovascular disease should be given Aventyl HCl under close observation and in low dosage. This drug, like members of its group, tends to produce sinus tachycardia and to prolong the conduction time, as manifested by first-degree AV block.

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Patients should be warned about the possibility of drowsiness if they operate dangerous machinery or drive a vehicle. Concurrent ingestion of other C.N.S. drugs or alcohol may potentiate the adverse effects of Aventyl HCl.

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Adverse Reactions: The following have been observed or reported following the use of Aventyl HCl: dryness of mouth, drowsiness, constipation, dizziness, tremulousness, confusional state, ataxia, disorientation and hallucinations, restlessness, weakness, precipitation of hypomanic or manic state, tachycardia, blurred vision, epigastric distress, sweating, peculiar taste, blacktongue, fatigue, excess weight gain or weight loss, insomnia, headache, paresthesia, nausea and vomiting, adynamic ileus, rash, itching, delayed micturition, hunger sensation, flushing, diarrhea, nocturia, inner nervousness, anxiety and panic, ankle and orbital edema, hypotension, hypertension, impotence, nightmares, palpitation, numbness, peripheral neuropathy, photosensitization, extrapyramidal symptoms, and increased or decreased libido.

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Aventyl HCl is preferably given in gradually increasing doses: 1 Pulvule (10 mg.) twice the first day, 1 Pulvule three times the second day, and 1 Pulvule four times daily thereafter.

If neither beneficial nor adverse effects are seen after five to seven days with 10 mg. four times a day, the patient can be given 25 mg. twice the first day, 25 mg. three times the second day, and 25 mg. four times daily thereafter.

If minor side-effects develop, reduce the dosage. If side-

effects of a more serious nature or allergic manifestations develop, discontinue the drug.

For mild symptoms of a depressive nature, give 10 mg. three or four times a day; for severe depressions, 100 mg. daily.

Dosages above 100 mg. daily seem to induce no greater degree of clinical response, but side-effects may increase.

Usual Recommended Dosage

ADULTS—20 to 100 mg. daily

Pulvules: 25 mg.—1 Pulvule one to four times daily
10 mg.—1 or 2 Pulvules one to four times daily

Liquid: 1 to 2 teaspoonfuls (5 to 10 cc.) one to four times daily

CHILDREN—1 to 2 mg. per Kg. or 10 to 75 mg. daily

Pulvules: 25 mg.—Ages seven to twelve, 1 Pulvule one to three times daily

10 mg.—Ages three to six, 1 Pulvule one to three times daily

Ages seven to twelve, 1 or 2 Pulvules one to three times daily

Liquid: Ages three to six, 1 teaspoonful (5 cc.) one to three times daily

Ages seven to twelve, 1 to 2 teaspoonfuls (5 to 10 cc.) one to three times daily

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Health Care

(Continued from page 645)

mate I believe the trend toward group practice will continue. I think it may be the only way that the smaller communities will be able to attract new physicians and specialists at the present time. I do believe, however, that most government health planners support group practice, not because more patients will be seen or for the other reasons that they give, but because they see in it the key to changes in health care financing, specifically development of prepaid health care as opposed to the fee for service concept. Knowing that this may arouse a hostile response, particularly from physicians, and raise the spectre of socialized medicine to the consumer, this argument in favor of group prepaid practice is usually soft-pedaled.

Health Care Delivery

Regardless of the type of practice arrangements that will prevail, I do believe national compulsory health insurance is just around the corner, and pressures for changes in health care delivery and financing will not be far behind. I don't wish to explore the pros and cons of prepaid care, but in any system the consumer should be able to get what he pays for, and until the quantity and quality of services are available to satisfy the needs, the government should go slow on its promises of delivery. Cutbacks in programs only serve to create more frustration and confusion, and the medical profession ends up as the whipping boy. An example of this are the many inferences from many sources that physicians are responsible for the high cost of medical care. The fees of physicians have gone up, but so has the overhead. His income has gone up, so have his hours of input and his work load. But the increase in physician fees as a contribution to the inflationary spiral in the health care system is a minor one. Seventy percent of health care costs are hospital costs and 70% of hospital costs are labor costs and other costs, such as food and commodities that are not peculiar to the health care sector. It is an appealing thought that the medical profession should control these things but they are, in our present economic climate, apparently uncontrollable in any sector.

In any discussion of health care delivery a recurrent theme is that of the team ap-

proach. Regardless of the method of care which ultimately develops, the needs cannot possibly be met without embracing the team concept. If we cannot produce enough physicians, perhaps we must find ways to make him more productive. With the physician as a team leader, and utilizing other team members and assistants for specific duties, more comprehensive care may be given to more people. To provide a continuum of care this must embrace a variety of people to include community health workers, social service workers, nurses and technicians.

There is some thought about the training of a different health professional with specific training designed to prepare him or her as an assistant to the physician. The assistant would work under the supervision of the physician, accomplishing those aspects of the practice as directed by the physician that are consistent with his training. One such program exists in rural Washington State which has many physician shortage areas comparable to our own. These former military corpsmen who have already had some significant training in service spend three months at the State Medical School and an additional 12 months as a preceptee in the office of a family physician. It is anticipated that the scope of his activity will include such things as doing portions of the physical examination, history taking, removal and application of casts, well baby care, suturing of simple lacerations, and even some counselling. I am sure the scope of activities will vary with the individual's ability, interest and aptitude. It has been shown that in truly physician deficient communities these people are accepted as an extension of the physician's arm and could be in part the answer to the dilemma of the small communities and the ghetto areas. In addition to the returning corpsmen as candidates for this field, we might be able to utilize the many students who never get accepted to medical school and are lost to the health field completely. The consumers of health care will have to adjust to these changes in health care delivery, and accept services from assistants, reserving for the physician those duties demanding the highest skills. Much needs to be done yet, however, before such assistants become widely used. Problems of training and licensure, and the threat of professional malpractice are all areas that remain to be explored.

(Continued on page 656)

Index To Volume 137

January through June, 1970

Page	1-102 January
	103-200 February
	201-306 March
	307-470 April
	471-570 May
	571-662 June

A

- "A Diphtheria Outbreak in Chicago" (Kallick, Brooks, Dover, Brown, Brolnitsky) 505
- Abel, Stuart, Zackler, Jack, Lehocky, Ronald, and Phillips, Hance C., "Maternal Mortality in Chicago" 163
- ABSTRACTS OF BOARD ACTIONS** 225; 483
- "Adaptation of Cardiac Catheterization Techniques for Insertion of Intravascular Cardiac Pacemakers" (Baffes, Blazek, and Adatto) 616
- Adatto, Irving J., jt. author. See Baffes, Thomas
- "Adrenal Neoplasm" (**SURGICAL GRAND ROUNDS**) (Beal, ed.) 47
- ALLERGY**, rhinocytology and its diagnostic possibilities in (Fischer-Pap) 611
- ANEMIA**, oral treatment of iron deficiency (**MEDICAL PROGRESS**) (Crawford) 60
- ANNUAL CONVENTION**, program 367

B

- Bachman, David C., "Medical Aspects of Professional Basketball" 149
- Baffes, Thomas, Blazek, William, and Adatto, Irving J., "Adaptation of Cardiac Catheterization for Insertion of Intravascular Cardiac Pacemakers" 616
- Baffes, Thomas G., jt. author. See Knock, Frances E.
- Balkoura, Maria H., Bhorade, Maruti S., Kahn, Sheldon M., Dunea, George, "Successful Pregnancy in a Woman with Severe Uremia" 80

- BASEBALL**, the medical aspects of professional (Suker) 89
- BASKETBALL**, medical aspects of professional (Bachman) 149
- Bauer, William, "The Other Side of the Coin" 158
- Beal, J. M., ed., (**SURGICAL GRAND ROUNDS**) 47; 139; 247; 347; 513; 603
- Bhorade, Maruti S., jt. author. See Balkoura, Maria H.
- Bigsby, Frank L., "Sustaining the Mood to Diet" 630
- Blazek, William, jt. author. See Baffes, Thomas

BOOK REVIEWS

- Artz, C. P., and Moncrief, J. A., **The Treatment of Burns** 42
- Bayne-Jones, Stanhope, **The Evolution of Preventive Medicine in the United States Army, 1607-1939** 256
- Beeson, Paul B. and McDermott, Walsh, **Textbook of Medicine** 147
- Bing's Local Diagnosis in Neurological Diseases**, 15th edition 538
- Converse, J. M., and Entin, M. A. (eds.), **Symposia on Reconstructive Plastic Surgery and on Surgery of the Hand** 43
- Cowdry, Edmund Vincent, **The Care of the Geriatric Patient** 346
- Fishbein, Morris, **An Autobiography** 256
- Gold, Jay J. (ed.), **Textbook of Gynecologic Endocrinology** 148

Griffenhagen, George B., Vol. 4-Private Die Proprietary Medical Stamps, Handbook No. 66 539

Hainlen, E. Willis, Vol. 3-Medical Stamps 539

Lynch, Matthew J., Raphael, Stanley S., Mellor, Leslie D., Spare, Peter D., Inwood, Martin J., Medical Laboratory Technology and Clinical Pathology 346

Meade, Richard Hardaway, An Introduction to the History of General Surgery 147

Medical Supply in World War II 346

Newell, Frank W., Ophthalmology Principles and Concepts (2nd edition) 609

Saunders, William H., and Paparella, Michael M., Atlas of Ear Surgery 42

Scheie, Harold G. and Albert, Daniel M., Adler's Textbook of Ophthalmology 538

USAMEDS, Infectious Diseases and General Medicine—The Historical Unit 148

Watson, Hamish (ed.), Pediatric Cardiology 43

Willson, J. Robert, Atlas of Obstetric Technic 609

Bredthauer, Sandra, "Doctor, Take A Second Look. . . ." (ILLINOIS MEDICAL ASSISTANTS ASSOCIATION) 628

Breed, J. Ernest, (PRESIDENT'S PAGE) 584

Brolnitsky, Olga, jt. author. See Kallick, Charles

Brooks, George F., jt. author. See Kallick, Charles, A.

Brown, Murray C., jt. author. See Kallick, Charles A.

Bucy, Paul C., "Our Responsibilities" 239

C

CANCER CHEMOTHERAPY aimed at cellular control mechanisms, clinical (Knock, et. al.) 229

Cannady, Edward W., (PRESIDENT'S PAGE) 10; 124; 209; 320; 489

CARDIAC CATHETERIZATION techniques for insertion of intravascular cardiac pacemakers, adaptation of (Baffes, Blazek, and Adatto) 616

CARDIAC PACEMAKERS, adaptation of cardiac catheterization techniques for insertion of intravascular (Baffes, Blazek, and Adatto) 616

CATHETERIZATION TECHNIQUES for insertion of intravascular cardiac pacemakers, adaptation of cardiac (Baffes, Blazek and Adatto) 616

CELLULAR CONTROL MECHANISMS, clinical cancer chemotherapy aimed at (Knock, et. al.) 229

CHICAGO, a diphtheria outbreak in (Kallick, Brooks, Dover, Brown, Brolnitsky) 505

CHICAGO, maternal mortality in (Abel, Zackler, Lehocky, Phillips) 163

CHILDREN, raising brighter (Ennis) 38

CHROMOSOME ABNORMALITIES and neuropsychiatric disorders, sex (Rowley) 528

CLINICS FOR CRIPPLED CHILDREN 41; 167; 280; 351; 539; 597

"Confrontation Technique Applied to Delirium and Confusional States" (Garner) 71

CONTRACEPTIVE DEVICES, morphological effects of intrauterine (Wynn) 333

CONVENTION HANDBOOK

- House of Delegates 369
- Officers & Administration 376
- Economics & Governmental Health Programs 394
- Education & Manpower 399
- Environmental & Community Health 402
- Finances & Budgets 408
- Legislation & Public Affairs 414
- Medical/Legal 417
- Mental Health & Addiction 419
- Public Relations & Membership Services 423
- Social & Medical Services 427
- Resolutions 430
- Convention Program 434
- Scientific Exhibits 439
- Technical Exhibits 442

Crawford, Oliver W., "Oral Treatment of Iron Deficiency Anemia" (MEDICAL PROGRESS) 60

D

Dakin, Alice R., jt. author. See Knock, Frances E.

DELEGATES HANDBOOK, Annual Convention Program 367

deHaen, Paul (NEW PHARMACEUTICAL SPECIALTIES) 20; 193; 286; 366; 490; 627

DELIRIUM and confusional states, confrontation technique applied to (Garner) 71

DICLOXACILLIN, response of staphylococcal respiratory infections to (Nathan) 290

DIET, sustaining the mood to (Bigsby) 630

DiGiulio, Vincent S., "Prolapsus Uteri with Pelvic Kidney" 344

DIPHThERIA outbreak in Chicago, A (Kallick, Brooks, Dover, Brown, Brolnitsky) 505

DIVERTICULUM of the esophagus, epiphrenic (SURGICAL GRAND ROUNDS) (Beal, ed.) 347

DOCTOR'S LIBRARY 42; 147; 256; 346; 538; 609

Dover, Arthur S., jt. author. See Kallick, Charles A.

Dunea, George, jt. author. See Balkoura, Maria

E

ECONOMICS, (SOCIO-ECONOMIC NEWS) (Lotharius) 83; 179; 283; 457; 545; 635

Economou, Steven, jt. author. See Vasquez, Richard M.

EDITORIALS, 40; 138; 245; 342; 551; 615

Ennis, Arthur L., "Raising Brighter Children" 38

"Epiphrenic Diverticulum of the Esophagus" (SURGICAL GRAND ROUNDS) (Beal, ed.) 347

ESOPHAGUS, epiphrenic diverticulum of the
(**SURGICAL GRAND ROUNDS**) (Beal, ed.)
347

F

FATALITY, report on: fluid extract of ipecac;
spider bite (Rose) 338
Fischer-Pap, Lucia, "Rhinocytology and Its Diag-
nostic Possibilities in Allergy" 611
FORENSIC MEDICINE in Illinois, future (Lewis)
253
FORENSIC PATHOLOGY, the growth of, in Il-
linois (Hirsch) 188
"Fractures of the Hand" (Siegel) 360
"Functional Interpretation of Placental Ultra-
structure" (Wynn) 523

G

Galt, Raymond M., jt. author. See Knock, Frances
E.
Garner, H. H., "Confrontation Technique Ap-
plied to Delirium and Confusional States" 71
"Gastric Obstruction from Gastrostomy Tube"
(Vazquez, Goldin, Economou) 357
GASTRIC TUMOR occluding the common bile
duct, the result of a prolapsed: intermittent
jaundice (Rukstinat, Saletta, and Tuleja) 595
GASTROINTESTINAL SURGEON, a new in-
sight for the (Sanders) 33
GASTROSTOMY TUBE, gastric obstruction from
(Vazquez, Goldin, Economou) 357
GENERATION GAP—1969 IMJ membership
opinion survey, 168
Gibbs, Jack L., "Health Care in the 70's" (**SPE-
CIAL ARTICLE**) 643
Goldin, Marshall, jt. author. See Vazquez, Rich-
ard M.
"Guidelines for Prescribing Physical Therapy"
355
GYNECOLOGICAL, vaginal surgery for non-
malignant conditions (Lash) 499

H

Haeflinger, Rosemarie, jt. author. See Knock,
Frances E.
HAND, fractures of the (Siegel) 360
"Health Care in the 70's" (Gibbs) (**SPECIAL
ARTICLE**) 643
HEMANGIOMA of the pericardium, primary
(Jablokow) 144
HEMOPHILIA, therapy for AHF and PTC Part
I, II (**MEDICAL PROGRESS**) (Seeler) 518, 598
HERNIA after vagotomy, hiatal (**SURGICAL
GRAND ROUNDS**) (Beal, ed.) 139
"Hiatal Hernia after Vagotomy" (**SURGICAL
GRAND ROUNDS**) (Beal, ed.) 139
Hirsch, Edwin F., "The Growth of Forensic
Pathology in Illinois" 188

I

**ILLINOIS MEDICAL ASSISTANTS ASSOCIA-
TION** 88; 178; 285; 451; 628
INFLUENZA EPIDEMIC SEASON, morbidity
patterns reflected in a school health program
during an (Leonida) 262
"Intermittent Jaundice: The Result of a Pro-
lapsed Gastric Tumor Occluding the Common
Bile Duct" (Rukstinat, Saletta, and Tuleja) 595
INTRAUTERINE CONTRACEPTIVE DEVICES,
morphological effects of (Wynn) 333
IPECAC, fluid extract, spider bite: report on
fatality (Rose) 338
IRON DEFICIENCY anemia, oral treatment
(**MEDICAL PROGRESS**) (Crawford) 60
Ivankovic, Anthony D., and Rattenborg, Chris-
ten C., "Management of Severe Status Asth-
maticus" 35

J

Jablokow, Victor R., "Primary Hemangioma of
the Pericardium" 144
JAUNDICE, intermittent: the result of a pro-
lapsed gastric tumor occluding the common
bile duct (Rukstinat, Saletta, and Tuleja) 595

K

Kahn, Sheldon M., jt. author. See Balkoura,
Maria H.
Kallick, Charles A., Brooks, George F., Dover,
Arthur S., Brown, Murray C., and Brolnitsky,
Olga, "A Diphtheria Outbreak in Chicago" 505
KIDNEY, prolapsus uteri with pelvic (DiGiulio)
344
Kiefer, Joseph H., "History of Urology in Illi-
nois" 54
Knock, Frances E., et. al., "Clinical Cancer
Chemotherapy Aimed at Cellular Control
Mechanisms" 229
Krumm, Janet, "Educate, Don't Vegetate" (**IL-
LINOIS MEDICAL ASSISTANTS ASSOCIA-
TION**) 178

L

Lash, A. F., "Vaginal Surgery for Non-Malig-
nant Gynecological Conditions" 499
Lawson, Lawrence J., "Reading and Learning
Problems—Ophthalmological Management" 623
LEADERSHIP CONFERENCE, 1970 44
LEARNING PROBLEMS—ophthalmological
management, reading and (Lawson) 623
Lehocky, Ronald, jt. author. See Abel, Stuart
Leonida, Domingo Dominic, "Morbidity Patterns
Reflected in a School Health Program During
an Influenza Epidemic Season" 262
Lewis, Samuel K., "Future Forensic Medicine
in Illinois" 253
Lotharius, Joseph (**SOCIO-ECONOMIC NEWS**)
83; 179; 283; 457; 545; 635

Love, Leon, (**THE VIEW BOX**) 52; 156; 238; 340; 522; 610

M

"Maternal Mortality in Chicago" (Abel, Zackler, Lehocky, Phillips) 163

MEDICAL PROGRESS

"Oral Treatment of Iron Deficiency Anemia" (Crawford) 60

"Therapy for AHF and PTC Hemophilia" (Seeler) Part I & II, 518, 598

"Medical Services in South Africa" (Voriss) 532

MEETING MEMOS 78; 183; 281; 354; 512; 656

MEMBERSHIP FORUM 53; 174; 271; 353; 555

"Membership Opinion Survey, What 'Generation Gap?'—1969" 168

MEMBERSHIP SURVEY, IMJ 1969 Survey Analysis—III 65

"Morbidity Patterns Reflected in a School Health Program during An Influenza Epidemic Season" (Leonida) 262

"Morphological Effects of Intrauterine Contraceptive Devices" (Wynn) 333

N

NEOPLASM, adrenal (SURGICAL GRAND ROUNDS) (Beal, ed.) 47

NEUROPSYCHIATRIC DISORDERS, sex chromosome abnormalities and (Rowley) 528

NEW PHARMACEUTICAL SPECIALTIES (de-Haen) 20; 193; 286; 366; 490; 627

O

OBITUARIES 93; 157; 292; 352; 537; 622

Oester, Y. Thomas, jt. author. See Knock, Frances E.

OPHTHALMOLOGICAL MANAGEMENT, reading and learning problems (Lawson) 623

"Oral Treatment of Iron Deficiency Anemia" (**MEDICAL PROGRESS**) (Crawford) 60

P

PACEMAKERS, adaptation of cardiac catheterization techniques for insertion of intravascular cardiac (Baffes, Blazek and Adatto) 616

"Pasteurella Multocida" (**SURGICAL GRAND ROUNDS**) (Beal, ed.) 247

PEER REVIEW GUIDELINES 265

"Pelvic Trauma" (**SURGICAL GRAND ROUNDS**) (Beal, ed.) 513

PERICARDIUM, primary hemangioma of the (Jablokow) 144

Phillips, Hance C. Jr., jt. author. See Abel, Stuart

PHYSICAL THERAPY, guidelines for prescribing 355

PHYSICIANS PLACEMENT SERVICE 64; 186; 289; 356; 554; 629

PLACENTAL ULTRASTRUCTURE, functional interpretation of (Wynn) 523

PREGNANCY, successful in a woman with severe uremia (Balkoura, Bhorade, Kahn, Dunea) 80

PRESIDENT'S PAGE 10; 124; 209; 320; 489; 584

"Prolapsus Uteri with Pelvic Kidney" (DiGiulio) 344

PUBLIC AFFAIRS LIBRARY 75; 162; 555; 622

R

Rattenborg, Christen C., jt. author. See Ivankovic, Anthony D.

"Reading and Learning Problems—Ophthalmological Management" (Lawson) 623

Renaud, Oliver V., jt. author. See Knock, Frances E.

RESPIRATORY INFECTIONS, response of staphylococcal to dicloxacillin, (Nathan) 290

RESPONSIBILITIES, our (Bucy) 239

"Retroperitoneal Mass" (**SURGICAL GRAND ROUNDS**) (Beal, ed.) 603

"Rhincytology and Its Diagnostic Possibilities in Allergy" (Fischer-Pap) 611

Rowley, Janet D., "Sex Chromosome Abnormalities and Neuropsychiatric Disorders" 528

Rubnitz, M. E., jt. author. See Knock, Frances E.

Rukstinat, George J., Saletta, Frank J., and Tuleja, Casimir W., "Intermittent Jaundice: The Result of a Prolapsed Gastric Tumor Occluding the Common Bile Duct" 595

S

Saletta, Frank J., jt. author. See Rukstinat, George J.

Sanders, Jack H., "A New Insight for the Gastrointestinal Surgeon" 33

SCHIZOPHRENIA and delinquency, the other side of the coin (Bauer) 158

Schmidt, Alexander M., "The University and Social Needs of the 70s" 133

Seeler, Ruth Andrea, "Therapy for AHF and PTC Hemophilia" (**MEDICAL PROGRESS**) Parts I and II 518, 598

"Sex Chromosome Abnormalities and Neuropsychiatric Disorders" (Rowley) 528

Siegel, Irwin M., "Fractures of the Hand" 360

SOCIAL NEEDS, and the university of the 70s (Schmidt) 188

SOUTH AFRICA, medical services in (Voriss) 532

SPIDER BITE, fluid extract of ipecac: report on fatality (Rose) 338

STATUS ASTHMATICUS, management of severe (Ivankovic, Rattenborg) 35

SUICIDE PREVENTION, experience in (Wilkins) 257

Suker, Joseph R., "The Medical Aspects of Professional Baseball" 89

SURGERY for non-malignant gynecological conditions, vaginal (Lash) 499

SURGICAL GRAND ROUNDS

"Adrenal Neoplasm" (Beal, ed.) 47

"Epiphrenic Diverticulum of the Esophagus" (Beal, ed.) 347

"Hiatal Hernia after Vagotomy" (Beal, ed.) 139

"Pasteurella Multocida" (Beal, ed.) 247

"Pelvic Trauma" (Beal, ed.) 513

"Retroperitoneal Mass" (Beal, ed.) 603

"Sustaining the Mood to Diet" (Bigsby) 630

Sylvester, Robert L., jt. author. See Knock, Frances E.

T

"The University and Social Needs of the 70s" (Schmidt) 133

"Therapy for AHF and PTC Hemophilia" Parts I & II (**MEDICAL PROGRESS**) (Seeler) 518, 598

Thomson, Betty, jt. author. See Knock, Frances E.

TRAUMA, pelvic (**SURGICAL GRAND ROUNDS**) 513

Tuleja, Casimir W., jt. author. See Rukstinat, George J.

U

UNIVERSITY and Social Needs of the 70s, (Schmidt) 133

UREMIA, successful pregnancy in a woman with severe (Balkoura, Bhorade, Kahn, Dunea) 80

UROLOGY, history of, in Illinois (Kiefer) 54

V

"Vaginal Surgery for Non-Malignant Gynecological Conditions" (Lash) 499

VAGOTOMY, hiatal hernia after (**SURGICAL GRAND ROUNDS**) (Beal, ed.) 139

Vazquez, Richard M., Goldin, Marshall, and Economou, Steven, "Gastric Obstruction from Gastrostomy Tube" 357

VIEW BOX 52; 156; 238; 340; 522; 610

Vogt, Phyllis, "Better Patient Care! ! !" (**ILLINOIS MEDICAL ASSISTANTS ASSOCIATION**) 285

Voris, Harold C., "Medical Services in South Africa" 532

W

Wahlberg, Monetta, "A Member's Viewpoints" (**ILLINOIS MEDICAL ASSISTANTS ASSOCIATION**) 451

Walter, Evelynne, "Why Should I Join?" (**ILLINOIS MEDICAL ASSISTANTS ASSOCIATION**) 88

Wilkins, James L., "Experience in Suicide Prevention" 257

Wynn, Ralph M., "Functional Interpretation of Placental Ultrastructure" 523

Wynn, Ralph M., "Morphological Effects of Intrauterine Contraceptive Devices" 333

Z

Zackler, Jack, jt. author. See Abel, Stuart

Malpractice Muddle

I find it baffling that physicians themselves aren't giving top priority to this crisis over malpractice suits. And I find it equally disturbing that, to my knowledge, no one in the medical profession has ever undertaken a comprehensive review of malpractice cases to identify the negligent acts involved and thus aid in devising techniques to prevent their recurrence.

Lee S. Goldsmith, a young New York trial lawyer who has a medical degree, recently applied for federal funds to finance such a project. If he receives a grant, he aims to sift through thousands of closed malpractice files, to catalog the recurring types of negligence.

Here's a sample of the kind of thing Dr. Goldsmith is looking for: one year in New York State there were fifty-five cases where sponges or surgical instruments were left in patients' bodies after operations. Figuring an average settlement of \$30,000, that totals up to \$1,650,000 in awards—in one state during one year. "That's a lot of money, yet we know there are still hospitals in the state that don't keep a count of instruments during operations," Dr. Goldsmith observes. Certainly, much research is needed into the root causes of malpractice and into ways to head off negligent acts before they occur. (Glynn Mapes. Will the Profession Settle the Malpractice Muddle—Or Will the Public?, **Medical Opinion & Review** [Apr. 1970, pgs. 120-122.]

Health Care

(Continued from page 650)

Conclusion

As you can see, planning for health care delivery in the next decade is a big order. It must include an increase in physician production and preferably a greater emphasis on the family or primary care physicians. It must include more effective delivery by the practicing physicians, and include the development of new health professionals. It may include the development of neighborhood health centers as a primary care source and it may mean development of first aid stations in rural communities manned by physician assistants associated with a nearby clinic or group practice to which proper communication and transportation has been arranged. As the federally sponsored comprehensive health planning gets underway, we must become involved. We must together identify unmet needs and plan together for their solutions, survey resources and set priorities. ◀

Rhinocytology

(Continued from page 614)

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Meeting Memos

June 19-21—American Medical Association

Council on Medical Education Meeting
Palmer House, Chicago

June 20-25—American Medical Association

Council on Scientific Assembly Meeting
Palmer House, Chicago

June 21—American School Health Association and AMA

Twelfth Annual Preconvention Session
International Amphitheater, Chicago

June 22-24—American College of Chest Physicians and AMA Fireside Grand Rounds

Conrad Hilton Hotel, Chicago

June 23-24—American Medical Society on Alcoholism and AMA Annual Meeting

American Hospital Association Building, Chicago

July 17-18—American Cancer Society and Colorado Medical Society 24th Annual Rocky Mountain Cancer Conference

Brown Palace Hotel, Denver

September 15-18—U.T.P. Exhibitions Ltd.

Bio-Medical Engineering Exhibition
West Hall, Olympia, London W14

The Mood To Diet

(Continued from page 633)

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Pamphlet

Unravelling the Mystery of Viruses has just been published by the National Society for Medical Research. The booklet, the second in the NSMR series of booklets on animal experimentation and the history of medicine, examines the growth of virology—from man's earliest attempts to combat viral infections to today's sophisticated science. Special attention is given to the critical role of animal research in achieving breakthroughs in knowledge. A wide distribution of the 32 page, illustrated publication is anticipated. It is designed primarily for lay readers and will be made available to high schools, colleges, and interested lay groups.

THE VIEW BOX

(Continued from page 610)

Diagnosis: Fig. 2

It is important to be acquainted with the signs of pneumoperitoneum which are present in a supine X-ray of the abdomen. When the patient lies on his back, free intraperitoneal air will collect under the anterior abdominal wall. If a degree of fluid is present in the abdomen there will be a layering-out effect with the air rising to the highest position, and outlining the entire peritoneal cavity laterally to the flanks as demonstrated in Fig. 1. Because of its shape, this has been called the "football sign." Ligamentous attachments on the anterior abdominal wall will appear as densities in the radiograph. There is a radiodense line which extends from the inferior margin of D-12 to the superior margin of L-3 close to the mid-line which represents the falciform ligament of the liver.

Other ligamentous attachments which occasionally may be seen are the remnant of the urachus which will present in the lower mid-line of the abdomen and extend up toward the umbilicus or remnants of the hypogastric arteries which extend toward the mid-line in the shape of an inverted V from the inguinal regions. The obliteration of the usual density of the liver results from the interposition of the free intraperitoneal air between the liver and the anterior aspect of the peritoneal lining. Fig. 2 in the upright position demonstrates the considerable amount of fluid in the pneumoperitoneum and the medial displacement of the liver and spleen by free air which interposes between the diaphragmatic leaves and the solid organs. You will also note air under the central tendon of the diaphragm. At surgery, a perforated gastric ulcer was demonstrated.

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Hemophilia

(Continued from page 602)

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New Pharmaceutical Specialties

(Continued from page 613)

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Illinois medical journal.
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